

Registration District No. 391

Primary Registration District No. 4230

Registrar's No. 45

1. PLACE OF DEATH:

(a) County IRIN  
(b) City or town IRINTON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST MARYS HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 DAYS  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County REYNOLDS  
(c) City or town ELLIINGTON MO  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 4  
year 1940 hour 12:15 noon M.

21. I hereby certify that I attended the deceased from 6-28  
\_\_\_\_\_, 1940 to 7-4, 1940  
that I last saw him alive on 7-4, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Tuberc Pneumonia

Due to \_\_\_\_\_  
Due to 108

Other conditions Pyloric  
(include pregnancy within 3 months of death)

Major findings:  
Of operations None  
Of autopsy None

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
969 (Specify type of place)  
(While at work?) (e) Means of injury \_\_\_\_\_  
23. Signature John W. [unclear] (M. D. or other)  
Address Irinton Mo Date signed \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME JAMES FRANKLIN CARTER

3. (b) If veteran, name war NO 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LETHA CARTER 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased MARCH 27 1898  
(Month) (Day) (Year)

8. AGE: Years 52 Months 3 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace LESTERVILLE MO  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMING

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name WILLIAM ZIMRI CARTER  
13. Birthplace REYNOLDS CO. MO  
(City, town, or county) (State or foreign country)  
14. Maiden name CAROLINA D. BOYD  
15. Birthplace LESTERVILLE MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs LETHA CARTER  
(b) Address ELLIINGTON MO

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ellington

18. (a) Signature of funeral director John G. [unclear]  
(b) Address \_\_\_\_\_

19. (a) July 6-40 (b) Julia A. Hunter  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

7/4/40....., Registered Apprentice No.....  
working under my personal supervision.

Signed Geo. P. Lemkel.....

Licensed Embalmer No. 3475.....

P. O. Address .....

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.