

AUG 16 1940
Registration District No. **449**

Primary Registration District No. **4267**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **LACLEDE**
(b) City or town **LEBANON**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **P. 3.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **MILES CARPENTER**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **VIOLA M HAMMER** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **DEC 6 1867**
(Month) (Day) (Year)

8. AGE: Years **71** Months **7** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **Mich.** (City, town, or county) (State or foreign country)

10. Usual occupation **CARPENTER**

11. Industry or business _____

MOTHER FATHER
12. Name **ANDREW CARPENTER**
13. Birthplace **VA**
14. Maiden name **WENCHMAN**
15. Birthplace **U.S.**

16. (a) Informant's own signature **Ray Carpenter**
(b) Address **Lebanon Mo.**

17. (a) **BURIAL** (b) Date thereof **7/20/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lebanon Cem.**

18. (a) Signature of funeral director **Palmer**
(b) Address **Lebanon Mo. 444**

19. (a) **7-24-40** (b) **J.A.M. Coult.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **LACLEDE**
(c) City or town **LEBANON**
(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 **July** day **24**
year **1940** hour **2** minute **-** A. M.
21. I hereby certify that I attended the deceased from **July 23**
~~July 23~~ to **July 24**, 19**40**
that I last saw him alive on **July 23** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion**
Due to _____
Due to **9412**

Other conditions (include pregnancy within 3 months of death) **none**
Major findings: **none**
Of operations _____
Of autopsy **none**

22. If death was due to external causes, fill in the following: **no**
(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
28. Signature **J. L. Beverage** (M. D. or other) _____
Address **Lebanon Mo.** Date signed **7/25/40**

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

RECEIVED

District Health Officer No. 7,

District File Number 8-40-1116

Date Filed 8-8-40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed S. P. Palmer

Licensed Embalmer No. 2208

P. O. Address Lebanon Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25342

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 449

Primary Registration District No. 4267

Registrar's No. _____

1. PLACE OF DEATH

(a) County Laclede
(b) City or town Bellevue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Miles Carpenter

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name B. A. Schuman

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Ray Carpenter
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-24-40 (b) J.A. McComb
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month July day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Bellevue

SUPPLEMENTARY

