

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

NOV 15 1940

35205

1. PLACE OF DEATH

County

Registration District No.

Township

Primary Registration District No.

City

(No.)

St.

Ward

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

March 2 1940

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

7

20

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Ava Mo

FATHER MOTHER

13. NAME

Willie Boyd Carter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Deleigles Co Mo

15. MAIDEN NAME

Wilma Mabel Givens

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Sparta

17. INFORMANT (ADDRESS)

Willie Boyd Carter Ava Mo R2

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Bruner

DATE

Oct 23 1940

19. UNDERTAKER (ADDRESS)

Friends

20. FILED 10-23

1940

Peta King White

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct-23, 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1940 to Oct. 22, 1940

I last saw him alive on Oct. 22, 1940. Death is said to have occurred on the date stated above, at 7 P. m.

The principal cause of death and related causes of importance were as follows:

Infectious Diarrhea Date of onset Oct 18-40

Other contributory causes of importance:

Name of operation

clined

Date of

What test confirmed diagnosis?

Was there an autopsy?

no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

R. M. Norman M. D.

(Address)

Ava Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im-

RECEIVED

District Health Officer No. 6,

District File Number 1140-2832.

Date Filed NOV 3 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35205

Registration District No. 272

Primary Registration District No. 3384

Registrar's No. 63

1. PLACE OF DEATH:

- (a) County Douglas
(b) City or town Boone T.P.
(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
years, months or days)

3. (a) PRINT
FULL NAME

Claude Carter

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex

7

5. Color or

race

W

6. (a) Single, widowed, married,

divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive

year

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

7

20

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

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(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) Citizen of foreign country (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct day 22
year hour minute M.

21. I hereby certify that I attended the deceased from

that last saw him alive on

and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Due to

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

R. M. Norman

(M. D. or other)

Address

ava mo

Date signed

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

KOWENH MOORE

