

No. 2  
1-13-40  
-17-39  
X23159

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1867  
Registrar's No. 97

Registration District No. 85 Primary Registration District No. 1001

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 Days  
(Specify whether years, months or days)  
In this community 40 Years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 319 S. 5th.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME PARSON BROWNLOW CARTER

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Ella Carter 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased March 12th. 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 10 9 hr. \_\_\_\_\_ min.

9. Birthplace Brown County Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Butcher

12. Name Thomas Carter

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

14. Maiden name Febble (unknown)

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

16. (a) Informant Mrs. Ella Carter

(b) Address 319 S. 5th. St. Joseph, Mo.

17. (a) Removal (b) Date thereof 1-24-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Horton Kansas

18. (a) Signature of funeral director FLEEMAN & SON, INC. 85

(b) Address St. Joseph, Mo.

19. (a) Jan 22, 1941 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 21st.  
year 1941 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 16, 1941 to Jan 21, 1941;  
that I last saw him alive on Jan 21, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Bilateral)  
Cardiac  
Due to Vascular Renal Disease

Due to 12/10

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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)  
(c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD  
Address [Signature] Date signed 1-22-41

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

**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 \_\_\_\_\_

*Carl W. House*

Licensed Embalmer No. \_\_\_\_\_

*3955*

P. O. Address \_\_\_\_\_

*St. Joseph, 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, fact should be so stated above.**