

FILED FEB 18 1941

Registration District No. 744 Primary Registration District No. 249 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ray Co. Mo.
 (b) City or town Richmond Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1 day ✓ 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community 2 days years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis MO
 (c) City or town Sedalia (If outside city or town limits, write "RURAL") 6
 (d) Street No. _____ (If rural, give location) 7
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John A. Carter

3. (b) If veteran, name war World War 3. (c) Social Security No. 083-29-6127

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

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

7. Birth date of deceased Oct. 14 - 1896
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u> 45	<u>3</u>	<u>10</u>	_____ hr. _____ min.

9. Birthplace 1 Kansas
 (City, town, or county) (State or foreign country)

10. Usual occupation Salmon

11. Industry or business Dr. Wm. F. Young & Co, Ill.

12. Name John A. Carter

13. Birthplace Ill. 1
 (City, town, or county) (State or foreign country)

14. Maiden name Jessie Carter

15. Birthplace Ill. 1
 (City, town, or county) (State or foreign country)

16. (a) Informant Thos Carter

(b) Address 2911 Angellique

17. (a) Burial (b) Date thereof Jan 25-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas

18. (a) Signature of funeral director W. H. ...

(b) Address Richmond Mo

19. (a) Jan 25-41 (b) Mal ...
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
 year 1941 hour 12 minute 26 a. M.

21. I hereby certify that I attended the deceased from 1-23-41, 19____, to 1-24-41, 19____; that I last saw him alive on 1-24-41, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarct Duration _____

Due to Coronary occlusion (complete)

Due to Generalized arteriosclerosis

Other conditions Pulmonary edema
 (Include pregnancy within 3 months of death)

Major findings: Of operations PHD

Of autopsy See causes of death **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? 9 105

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature H. W. Griffith (M. D. or other) PHD

Address Richmond Mo Date signed 1-24-41

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

19

APR 3 1947

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.....

Signed.....

Licensed Embalmer No. 2007

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40 18-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 744

Primary Registration District No. 2035

Registrar's No.

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Richmond
(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 John A. Carter

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

4. Sex m 5. Color of 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 oct 14 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 3 10 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

(a) Jan 26-41 (b) McLendon
(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.

20. DATE OF DEATH: Month Jan day 24
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ 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 W. M. Gafayth (M. D. or other) _____

Address Richmond Date signed _____

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4015-7

Registration District No. 744

Primary Registration District No. 3035-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Richmond
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Richmond Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: 2 days (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME John A. Carter

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 Months Days If less than one year
44 3 10 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) Jan 26-41 (b) Malcolm Jackson
(If he 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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
year 1941 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 _____

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) _____ (e) Means of injury _____

23. Signature H. M. Griffith (M. D. or other)
Address Richmond Mo Date signed _____

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

SUPPLEMENTARY