DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8307

FILED MAR 19 1941

Registration District No. 797

Primary Registration District No. 4477

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Miami
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

(c) City or town Miami
(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.

3. (a) PRINT FULL NAME Sallie B. Carter

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Isaac Carter

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased April (Month) 14 (Day) - 1859 (Year)

8. AGE: Years 81 Months 9 Days 27 If less than one day ____ hr. ____ min.

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

10. Usual occupation House wife

11. Industry or business ____

FATHER
12. Name Dont Know
13. Birthplace Dont Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace ____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gibson Hillman
(b) Address Miami Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12 41 (Month) (Day) (Year)
(c) Place: burial or cremation Miami

18. (a) Signature of funeral director Geo Wilson
(b) Address Miami Mo

19. (a) 2-12-41 (Date received local registrar) (b) Mrs. Arline Hisle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2nd day 11
year 1941 hour 9 minute 45 A M.

21. I hereby certify that I attended the deceased from 8-16, 1939, to 2-11, 1941;
that I last saw her alive on 1-27, 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	26 days
Due to	
Due to	Probably many years
Other conditions arteriosclerosis (Include pregnancy within 3 months of death)	

107

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

23. Signature [signature] (M. D. or other)
Address Miami, Mo. Date signed 2/11/41

(Licensed Embalmer's Statement on Reverse Side)

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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

RECEIVED
Date Filed 3-4-41

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.....

Licensed Embalmer No.....

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.

. No. 2
—1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8307

Registration District No. 797 Primary Registration District No. 4477 Registrar's No.

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Miami
(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)

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

3. (a) PRINT FULL NAME Sallie B Carter

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race Black

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Apr 14 1859
(Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) 2-12-41 (Date received local registrar) (b) Mrs. Orlin Hoste (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 11
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.

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature O. H. Sullivan (M. D. or other)
Address Miami Mo Date signed

SUPPLEMENTARY

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.