

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 26 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

14416

Registration District No.

957

Primary Registration District No.

5396

Registrar's No.

1. PLACE OF DEATH:

- (a) County Douglas
 (b) City or town Union Bridge, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1. Methodist
 (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 months

3. (a) PRINT
FULL NAMELona Y. Henry Carter3. (b) If veteran,
name war _____3. (c) Social Security
No. _____

4. Sex Male 5. Color or White 6. (a) Single, widowed, married
 divorced Child
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased Jan 13th 1941
 (Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

hr. min.

9. Birthplace

Union Bridge, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

unpaid

11. Industry or business

12. Name

Ray Carter

13. Birthplace

Mo.
(City, town, or county) (State or foreign country)

14. Maiden name

Elta Johnson

15. Birthplace

Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant

Ira Johnson

(b) Address

Union Bridge

17. (a)

the Burial
(Burial, cremation, or removal)

(b) Date thereof

3-21-41
(Month) (Day) (Year)

(c) Place: burial or cremation

Thornton Cemetery

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 MO (b) County Douglas
 (c) City or town Selma, Mo.
 (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 Mar day 21
year _____ hour _____ minute _____ M.21. I hereby certify that I attended the deceased from
3/16, 1941 to 3/21, 1941
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death

Meningitis 7 days

Due to

Influenza 3 days

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 sta-
tistically.

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?
975

While at work

(Specify type of place)

23. Signature Maxwell Thayer (M. D. or other)
Address West Plains Date signed 3/21/41

RECEIVED

District Health Officer No. 5,

District File Number 5411599

Date Filed _____

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

ms 8-12

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14416

Registration District No. 957 Primary Registration District No. 5396 Registrar's No. 64

1. PLACE OF DEATH:

(a) County Douglas
(b) City or town Richland 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 Lona V Henry 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 _____
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 2 Days _____ If less than one day _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-23-1941 (b) Reba K. White
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 21
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 _____ 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) (c) Means of injury _____

23. Signature Murice Thompson (a) or other _____
Address West Plains Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAE

SUPPLEMENTARY

S-14416