

Registration District No. **347**

Primary Registration District No. **5490**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Herry  
 (b) City or town Clinton Rural, Field Creek  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution 5 miles north of Clinton  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution nat.  
 In this community 60 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Herry  
 (c) City or town Clinton Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Field Creek Trp. N.W.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME JAMES EDWARD McCARTY  
 3. (b) If veteran, name war none  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct - 25 - 1941  
 year \_\_\_\_\_ hour 7:30 minute \_\_\_\_\_ A. M.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Aug 18 1853  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-1 1941, to 10-25 1941;  
 that I last saw him alive on 10-24- 1941;  
 and that death occurred on the date and hour stated above.

8. AGE: Years 88 Months 2 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Sarcemia of chest of 10 mo  
& heart  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

10. Usual occupation farmer & merchant  
 11. Industry or business \_\_\_\_\_  
 12. Name Col. E. C. McCarty  
 13. Birthplace Virginia  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Mary Kapshins  
 15. Birthplace Virginia  
 (City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant's own signature Mrs. Will Evans  
 (b) Address Clinton Mo. R.H.  
 17. (a) Burial (b) Date thereof Oct 26 41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Englewood Cem  
 18. (a) Signature of funeral director N. A. Vassant  
 (b) Address Clinton, Mo.  
 19. (a) 10-25-41 (b) Dr. J. R. Hampton  
 (Date received local registrar) (Registrar's signature)

23. Signature H. Walker (M. D. or other) M.D.  
 Address Clinton Mo Date signed 10-25-41

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.

RECEIVED

District Health Officer No. 7;

District File Number 11-41-1904

Date Filed 11-14-41

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~~

H. A. Vansant, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

H. A. Vansant

Licensed Embalmer No.

3779

P. O. Address

Clinton, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35081  
Registrar's No. ....

Registration District No. 341

Primary Registration District No. 5490

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Rural  
(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

James E. McCarty

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 S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 13  
(Month) (Day) (Year)

8. AGE: Years 88 Months 2 Days \_\_\_\_\_  
(If less than one day \_\_\_\_\_ 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 \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 25  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 Sarcoma of cheek & jaw Duration \_\_\_\_\_

Due to Sarcoma in mouth (left cheek & lower lip)

Due to muscular region

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 J. J. [unclear] (M. D. or other) M.D.

Address Clinton mo Date signed 12-12-41

SUPPLEMENTARY

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

