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4-41
7-39
X26390

Registration District No. **1052**

Primary Registration District No. **3510**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Hickory
 (b) City or town Center Rural
(If outside the city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Center Hosp
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)
 In this community 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Hickory ⁰⁴³
 (c) City or town Center - Rural ¹⁰
(If outside city or town limits, write "RURAL")
 (d) Street No. Jules (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME James K. Carter
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 17
 year 1941 hour 11 minute 30 M. ^P

4. Sex m 5. Color or race whk 6. (a) Single, widowed, married, divorced widower
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 13, 1857
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept-1- 1941, to Oct-12- 1941;
 that I last saw him alive on Sept-27- 1941;
 and that death occurred on the date and hour stated above.

8. AGE: Years 89 Months 8 Days 29 If less than one day _____ hr. _____ min.

Immediate cause of death Osteomyelitis of tibia left leg
 Duration About 6 wks.

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

Due to _____
 Due to _____

10. Usual occupation Farmer

Other conditions _____
(Include pregnancy within 3 months of death)

11. Industry or business _____

Major findings: _____
 Of operations _____
 Of autopsy _____
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 { 12. Name Alben Carter
 { 13. Birthplace Tenn (City, town, or county) (State or foreign country)
 { 14. Maiden name Nancy Blackwell
 { 15. Birthplace Mo (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? _____

16. (a) Informant Alben Carter
 (b) Address Wheatland, Mo
 17. (a) General (Burial, cremation, or removal) (b) Date thereof 10/14/41 (Month) (Day) (Year)
 (c) Place: burial or cremation Wheatland, Mo

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

18. (a) Signature of funeral director J.P. Luker
 (b) Address Wheatland, Mo
 19. (a) Oct-11-41 (Date received local registrar) (b) W.E. Brenner (Registrar's signature)

23. Signature A.S. Johnston (M. D. certifying)
 Address Wheatland, Mo Date signed 10-13-41

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

RECEIVED

District Health Officer No. 7,

File Number 11-41-1917

Page 11-24-41

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

J. Luc Key

Licensed Embalmer No. 7982

P. O. Address Chattanooga

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.