

FILED JUL 23 1942
Registration District No. **294**

Primary Registration District No. **54092**

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

66006

1. PLACE OF DEATH:

(a) County **Franklin**

(b) City or town **Rural Central**
(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 years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Franklin**

(c) City or town **Rural Central** **36**
(If outside city or town limits, write "RURAL")

(d) Street No. **0**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) **PRINCE**
FULL NAME **Jessie Washington Carpenter**

3. (b) Veteran, name war **no**

3. (c) Social Security No. **no**

MEDICAL CERTIFICATION

DATE OF DEATH: Month **June** day **27**
year **1942** hour **1** minute **30 P.** M.

4. Sex **male**

5. Color or Race **W**

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

6. (b) Name of husband or wife **Ida C. Carpenter**

6. (c) Age of husband or wife if alive **71** years

7. Birth date of deceased **9-11-71-1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **6-27-42** to **6-27-42**
that I last saw him alive on **June 26** 19**42**
and that death occurred on the date and hour stated above.

8. AGE: Years **67** Months **9** Days **16**
If less than one day _____ hr. _____ min.

Immediate cause of death **Cerebral apoplexy**
Cerebral hemorrhage
Due to **arteriosclerosis - Insp.**

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

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

10. Usual occupation **laborer**

MOTHER FATHER

11. Industry or business _____

12. Name **Jess Carpenter**

13. Birthplace **Georgia** (City, town, or county) _____ (State or foreign country) _____

14. Maiden name **Helen Edder**

15. Birthplace **North Carolina** (City, town, or county) _____ (State or foreign country) _____

PHYSICIAN _____

Major findings: _____
Of operations _____

Of autopsy **g 301**

16. (a) Informant **Mrs Ida C. Carpenter**

(b) Address **517 E. 2nd**

17. (a) **Burial** (Burial, cremation, or removal) _____ (b) Date thereof **6-29-42**
(Month) (Day) (Year)

(c) Place: burial or cremation **Breen funeral**

18. (a) Signature of funeral director **Sherrwood Kitchell**

(b) Address **St. Clair 720**

19. (a) **6/29/1942** (Date received local registrar) _____ (b) **P. J. King** (Registrar's signature)

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) Months of injury _____

23. Signature **W. E. Kitchell** (M. D. or other) _____ **6/28/42**
Address **St. Clair** Date signed _____

#P

1120

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.....

Sherwood Mitchell

Licensed Embalmer No.....

3873.

P. O. Address.....

St. Clair 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, fact should be so stated above.