

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6433**
Registrar's No. **7**

FILED FEB 15 1943
Registration District No. **3023**

Primary Registration District No. **3023**

1. PLACE OF DEATH:
(a) County **Henry**
(b) City or town **Clinton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Susie Carter**
3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

4. Sex **Female** 5. Color or race **3 Negro** 6. (a) Single, widowed, married, divorced **1 divorced**
6. (b) Name of husband or wife **John** 6. (c) Age of husband or wife if alive **FD** years
7. Birth date of deceased **Feb 14 - 1869**
(Month) (Day) (Year)

8. AGE: Years **73** Months **10** Days **7** If less than one day hr. min.

9. Birthplace **St Clair County, Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Tom Parker**

12. Name **unknown**

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 **Nora Carter**

(b) Address **Clinton Mo**

17. (a) **Burial** (b) Date thereof **Dec 26 - 42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clinton Cal Cem**

18. (a) Signature of funeral director **J. P. & Son**

(b) Address **Clinton Mo**

19. (a) **Dec. 21, 1942** (b) **Georgia Kitchener**
(Date received local registrar) (Registrar's signature) **G.K.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Henry**
(c) City or town **Clinton**
(If outside city or town limits, write "RURAL")
(d) Street No. **Smith St**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) **No**
If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **21** ch
year **1942** hour **2 PM** minute **0** M.

21. I hereby certify that I attended the deceased from **Thurs. 22** 19**42** to **Dec 22, 1942**
that I last saw her alive on **Dec 14, 1942**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Uterus**
Duration **1 year**

Due to **48 h**
Due to **Uremia**
Other conditions (Include pregnancy within 3 months of death) **one week**

Major findings: Of operations **Uremia**
Of autopsy **one week**

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 **Dr. R. H. Hall** (D. or other) **7. P.**
Address **Clinton Mo** Date signed **12/24/42**

RECEIVED
District Health Officer No. 7
District File Number 1-43-114
Date Filed 2-8-43

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed W. Kenneth Jackson
Licensed Embalmer No. 3954
P. O. Address Clinton Snd

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.