

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14076**  
Registrar's No. **25**

LED MAY 8 1943  
Registration District No. **3015**

Primary Registration District No. **3015**

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

(b) If veteran, name war **no** (c) Social Security No. **None**

Female  
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
(b) Name of husband or wife **E. J. D. Carter** (c) Age of husband or wife if alive **79** years  
7. Birth date of deceased **March 6 1869** (Month) (Day) (Year)

8. AGE: Years **74** Months **0** Days **16** If less than one day hr. min.

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

10. Usual occupation **Housework in Home**

11. Industry or Business

12. Name **Jacob Dice**  
13. Birthplace **Germany** (City, town, or county) (State or foreign country)  
14. Maiden name **Anna Balk**  
15. Birthplace **Ky** (City, town, or county) (State or foreign country)

16. (a) Informant **Ellen Weiss** (b) Address **Cameron, Mo.**

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof **April 4, 1943** (Month) (Day) (Year)  
(c) Place: burial or cremation **Christian Chapel, Dekalb Co. Mo.**

18. (a) Signature of funeral director **W. H. Moore** (b) Address **Cameron, Mo.**

19. (a) **Apr. 2, 1943** (b) **Mrs. Kathleen Harris** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clinton**  
(c) City or town **Cameron** (If outside city or town limits, write "RURAL")  
(d) Street No. **628 East 2nd** (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **XXXXX**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **31st** year **1943** hour **5** minute **20** A.M.

21. I hereby certify that I attended the deceased from **3-24-1943** to **3-31-1943**; that I last saw her alive on **3-31-1943**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis** Duration **3-24-1943 to 3-31-1943**

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?

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

23. Signature **W. H. Bloom** (M. D. or other) **W. H. Bloom**  
Address **Cameron, Mo.** Date signed **4-2-43**

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

Signed \_\_\_\_\_

Licensed Embalmer No. 1180

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, fact should be so stated above.