S. No. 2
1—9-4-41
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

LED JUN 3 1943 128

Registration District No. ~~315~~

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 17832

Registrar's No. 354

1. PLACE OF DEATH:

(a) County: GREENE

(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2½ Days (Specify whether years, months or days)

In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Springfield (If outside city or town limits, write "RURAL")

(d) Street No.: 817 N. Weaver (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: 0

39 2 6

3. (a) PRINT FULL NAME: William Carter

3. (b) If veteran, name war: Unknown

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: Colored

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

6. (b) Name of husband or wife: None

6. (c) Age of husband or wife if alive: XX years

7. Birth date of deceased: October (Month) 15 (Day) 1889 (Year)

8. AGE: Years: 53 Months: 6 Days: 19 If less than one day: hr. min.

9. Birthplace: Unknown (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Jacob Carter
13. Birthplace: Unknown (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name: Bettie Shields
15. Birthplace: Unknown (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant: Hattie Farris
(b) Address: 817 N. Weaver

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-9-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Hazelwood Cem.

18. (a) Signature of funeral director: W. P. Campbell
(b) Address: 867 Washington Ave

19. (a) 5-8-43 (Date received by local registrar) (b) R. W. Hanlly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 4th year: 1943 hour: 9:30 minute: A. M.

21. I hereby certify that I attended the deceased from May 2nd, 1943, to May 4th, 1943 that I last saw him alive on May 3rd, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sub-Dural Hemmorhage	2½ Days
Due to: Fracture of Skull	"
Due to:	
Other conditions: Poss. Internal Injuries (Include pregnancy within 3 months of death)	"

Major findings:
Of operations: Collision with pedestrian
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): Accident 138
(b) Date of occurrence: 5-2-43
(c) Where did injury occur? Springfield (City or town) Greene (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Struck by City Bus while crossing street (Specify type of place)
While at work? (e) Means of injury: City Bus

23. Signature: R. E. Johnson (M. D. or other) M.D.
Address: 302 College St. Date signed: 5-8-43

(Licensed Embalmer's Statement on Reverse Side)

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 W. P. Campbell

Licensed Embalmer No. 1747

P. O. Address Springfield Me

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.