

S. No. 2
M-5-42
5-17-39
I X32873

19164

State File No. _____

Registrar's No. **#10109**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 10 1943

Registration District No. **224**

Primary Registration District No. **3072**

1. PLACE OF DEATH:

(a) County **Saline**
(b) City or town **Marshall**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Putnam Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 Days**
(Specify whether
In this community **All his life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saline**
(c) City or town **Marshall**
(If outside city or town limits, write "RURAL")
(d) Street No. **116 1/2 North Lafayette**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Arista L. Carpenter**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 10th, 1856**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 0 19 hr. _____ min.

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

10. Usual occupation **Retired farmer**

11. Industry or business _____

12. Name **Robert Carpenter**

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

14. Maiden name **Adaline Laoy**

15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Tom Carpenter**
(b) Address **1075 1/2 South Brunswick**

17. (a) **Burial** (b) Date thereof **May 31-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Carmel Cemetery**

18. (a) Signature of funeral director **Compass-Rite**
(b) Address **Marshall, Mo.**

19. (a) **6-1-43** (b) **Mo T. O. Whelton**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **May** day **29th**
year **1943** hour **5** minute **7** A.M.

21. I hereby certify that I attended the deceased from **April 10th**
1943 to **May 28th** **1943**
that I last saw him alive on **May 25th** **1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Senility**

Due to **Jauundice** **9 months**

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 **J. L. Emerson** (M. D. or other) _____
Address **Marshall Mo.** Date signed **5-29-43**

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

1211

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 6-9-43

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, 6-9-43

Registered Apprentice No. _____

working under my personal supervision:

Signed

Jan. N. Lewis

Licensed Embalmer No. 1171

P. O. Address Marshall 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.