

34545

State File No. \_\_\_\_\_

Registrar's No. 96

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

No. 2  
-2-43  
17-  
X35897

Primary Registration District No. 4165

FILED OCT 20 1943 98  
Registration District No. 98

1. PLACE OF DEATH:

(a) County Daviess

(b) City or town Gallatin  
(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  
In this community 2 Weeks \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess 31

(c) City or town "Rural" Union Township  
(If outside city or town limits, write "RURAL") 0

(d) Street No. --- (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Smith Hezekiah Carter

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 Widowed

6. (b) Name of husband or wife Effie Belle Carter

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

7. Birth date of deceased October 25 1877  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>10</u>	<u>15</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Wesley Carter

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

14. Maiden name Malissa Critten

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

16. (a) Informant John W. Carter

(b) Address Gallatin, Mo.

17. (a) Burial (b) Date thereof 9-12-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centenary Sometery

18. (a) Signature of funeral director Hope Furn. & Dndg. Co.

(b) Address Gallatin, Mo.

19. (a) 9-11-1943 (b) S. D. Jackson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 10  
year 1943 hour 10 minute 45 P. M.

21. I hereby certify that I attended the deceased from July 1943 to Sept 10 1943  
that last saw him alive on Sept 10 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Hemorrhagic Nephritis + Mas.

Due to Arterial Sclerosis + Mas.

Due to Myocarditis + Mas.

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature Hyd E. Nelson (Specify type of place) 3  
Address Gallatin, Mo. Means of injury \_\_\_\_\_  
Date signed 9-11-43

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

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

*L. O. Richardson*

Licensed Embalmer No.

*3302*

P. O. Address

*Gallatin 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.

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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

REC'D NOV

Registration District No. 98

Primary Registration District No. 4165

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town Callahan  
(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  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Smith H. Carter

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Oct. 25  
(Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

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 \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day \_\_\_\_\_  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; \_\_\_\_\_ 19\_\_\_\_;

that I last saw him/her alive on Sept 10, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death acute glomerulonephritis Duration \_\_\_\_\_

acute Exacerbation of chronic nephritis

Due to arterial degeneration

Due to myocarditis

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? \_\_\_\_\_

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

23. Signature Charles H. DeLoe (M. D. or other) \_\_\_\_\_

Address Callahan, Mo. Date signed 10-24-43

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

SUPPLEMENTARY

34545