S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 23 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8567

Registration District No. 355 Primary Registration District No. 6202 Registrar's No.

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Summersville Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural Carroll Tp. No. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether
In this community 32 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED: 107
(a) State Missouri (b) County Texas 0
(c) City or town Summersville Mo 0 (If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mary Jane Carpenter
3. (b) If veteran, name war No.
3. (c) Social Security No. No
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, 2 divorced Widowed
6. (b) Name of husband or wife William H Carpenter
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. (Month) 7th (Day) 1870 (Year)

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

9. Birthplace (City, town, or county) Tenn. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name John Antrican
13. Birthplace (City, town, or county) Tenn (State or foreign country)
MOTHER
14. Maiden name Martha Mays
15. Birthplace (City, town, or county) Tenn (State or foreign country)
16. (a) Informant Mrs. Carl Carpenter
(b) Address Summersville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15-44 (Month) (Day) (Year)
(c) Place: burial or cremation Bethel Chappell
18. (a) Signature of funeral director John F Amelan
(b) Address Mtn View Mo.
19. (a) 2/17/44 (Date received local registrar) (b) Mrs Paul Kelsey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14th year 1944 hour 5 minute am.
21. I hereby certify that I attended the deceased from 5 PM Feb 13, 1944, to 5:45 PM Feb 13 1944 that I last saw her alive on Feb 13, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy
Due to Hypertension
Due to Asthma
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 2
23. Signature Lavere Hampton (M. D. or other) Do
Address Summersville Date signed Feb 15

1341

(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 John F Duncan

Licensed Embalmer No. 2516

P. O. Address Mtn View 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 25J — Primary Registration District No. 6202 — Registrar's No.

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Summersville, Mo.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

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 .....

3. (a) PRINT FULL NAME Mary Jane Carpenter

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

3. (c) Social Security No. .....

4. Sex F

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 Feb. (Month) 7 (Day) 1870 (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... Day ..... year 1944 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death ..... *Duration*

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 ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

8567