

No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22631

FILED JUL 10 1944

Registration District No. 379

Primary Registration District No. 4469

State File No.

Registrar's No. 30

1. PLACE OF DEATH:

(a) County ST. GENEVIEVE
(b) City or town _____
(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 _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 95
(c) City or town ST. GENEVIEVE
(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 EFFIE ADELIKE CARTEE

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

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased SEPT. 4 1878
(Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 23
If less than one day _____ hr. _____ min.

9. Birthplace BONNE TERRE MO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business _____

MOTHER FATHER
12. Name ANDREW GENTERY
13. Birthplace DONT KNOW
14. Maiden name NANCY PAULINE
15. Birthplace DONT KNOW

16. (a) Informant MRS. EDWARD ADE
(b) Address ST. GENEVIEVE MO

17. (a) BURIAL (b) Date thereof _____
(c) Place: burial or cremation PARK VIEW

18. (a) Signature of funeral director P. J. Dwyer
(b) Address 1214 E. 2nd St.

19. (a) June 29/44 (b) T. W. Douglas
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 27th
year 1944 hour 6 minute - A.M.

21. I hereby certify that I attended the deceased from June 27 1944 to June 27 1944
that I last saw her alive on June 27
and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiac dilatation
Secondary Anemia
Due to Malnutrition of R.L. lung

Other conditions (Include 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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature T. W. Douglas (M. D. or other) MD
Address St. Genevieve MO Date signed 6-28-44

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

005

706

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4
District File Number 744-4076
Date Filed 7-8-44

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..... C. Z. Boyer
Licensed Embalmer No. 1617
P. O. Address..... Desloge 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 30

Registration District No. 319 Primary Registration District No. 4469

1. PLACE OF DEATH:
(a) County St. Genevieve
(b) City or town See Genevieve
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Gen.
(c) City or town St. Genevieve
(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 Effe A. 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 Sept 4 1907
(Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 4 If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

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) (Date received local registrar)..... (b) T.W. Douglas (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 24 year 1944 hour 10 minute 15 M.
21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions..... (Include 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?
While at work?..... (Specify type of place)
(e) Means of injury.....

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

SUPPLEMENTARY

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22631