

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

FILED NOV 25 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37115

Registration District No. 38

Primary Registration District No. 3006-5120

State File No. _____

Registrar's No. 251

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia - Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Columbia
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: no
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. " 75
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country x

3. (a) PRINT FULL NAME WM J 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 m
6. (b) Name of husband or wife Ada Bullard Carter 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 6 1865
(Month) (Day) (Year)

8. AGE: Years 79 Months 2 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name John W Carter
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Haben
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant M R Thurston
(b) Address Columbia Mo

17. (a) Burial (b) Date thereof Oct 5 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia, Cem

18. (a) Signature of funeral director R. P. [Signature]
(b) Address Columbia

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3rd
year 1944 hour 5:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on Oct 3, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Branchial Pneumonia
Due to Senile Degenerities

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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? _____

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

23. Signature R. P. [Signature] (M.D. or other) RD.
Address Columbia Date signed 10/3/44

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

1250

(Licensed Embalmer's Statement on Reverse Side)

1378A 1378A

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 11-22-44

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 [Signature]

Licensed Embalmer No. 3183

P. O. Address Columbia

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. DecRegistration District No. 38Primary Registration District No. 5120Registrar's No. 251

1. PLACE OF DEATH:

(a) County Boone
 (b) City or town Columbia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rural Route 40
 (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 Wm J. 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 m

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

7. Birth date of deceased July 6 1882
 (Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ min.

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

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) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-5-44 (b) Edna H. Park
 (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 Oct Day 13
 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1944
S-37115