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Dr. R. Williams

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1944

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37743

Primary Registration District No. 2010

Registrar's No. 929

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

1. PLACE OF DEATH:

(a) County: GREENE

(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 780 W. Lincoln
(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: 35 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Springfield
(If outside city or town limits, write "RURAL")

(d) Street No.: 780 W. Lincoln
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Thomas D. Carter

3. (b) If veteran, name war: No

3. (c) Social Security No.: 491-03-7871

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Cecil Carter

6. (c) Age of husband or wife if alive: 54 years

7. Birth date of deceased: August (Month) 26 (Day) 1884 (Year)

8. AGE: Years 60 Months 2 Days 29 If less than one day ..... hr. ..... min.

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

10. Usual occupation: Building Contractor

11. Industry or business: .....

FATHER
12. Name: John W. Carter
13. Birthplace: Unk. (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name: Margaret Roena Alsup
15. Birthplace: Unk. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs. Cecil Carter

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/30/44 (Month) (Day) (Year)

(c) Place: burial or cremation: Lindenlure, Mo.

18. (a) Signature of funeral director: H.H. Lohmeyer

(b) Address: Springfield, Mo.

19. (a) 11-27-44 (Date received local registrar) (b) W E Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov. day: 25 year: 1944 hour: 6 minute: 40 p.m.

21. I hereby certify that I attended the deceased from Nov 24, 1944, to Nov 25, 1944, that I last saw him alive on Nov 25, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage	Duration: 2 Days
Due to:	
Due to:	
Other conditions: None (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy:	

83a

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): None

(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: Robert F Williams (M. D. ~~or other~~)

Address: Springfield Mo Date signed: 11-27-44

(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 Walter E Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield 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.