

7. S. No. 2
FORM-2-43
rev. 5-17-39
I X35637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41024

State File No. _____

FILED JAN 12 1945

Registration District No. 97

Primary Registration District No. 5344

Registrar's No. _____

1. PLACE OF DEATH:

(a) County DADE
(b) City or town NORTH TOWNSHIP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: E. of NEOLA
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 7 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME CHARLES EDWARD M^cCARTER

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased JULY 12 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 5 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation FARMER

11. Industry or business _____

12. Name DANIEL M^cCARTER

13. Birthplace NO RECORD
(City, town, or county) (State or foreign country)

14. Maiden name MAE HUNT

15. Birthplace NO RECORD
(City, town, or county) (State or foreign country)

16. (a) Informant W^m M^cCarter

(b) Address Greenfield, Mo.

17. (a) BURIAL (b) Date thereof 12-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREENFIELD, Mo

18. (a) Signature of funeral director Sam B. Sweeney

(b) Address Greenfield, Mo.
19. (a) 12-23-44 (b) W. H. Kirby
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 16
year 44 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from 12-13 1944 to 12-16 1944
that I last saw him alive on 12-13 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to _____

Due to 942

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 W. H. Kirby (M. D. or other) _____
Address Greenfield Mo Date signed 12-20-44

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

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

MOTHER FATHER

1343

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 145-12

Date Filed JAN 9 1945

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 Sam E. Sencer

Licensed Embalmer No. 4099

P. O. Address Greenfield, 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.