

1. PLACE OF DEATH

(a) County *Shrewsbury*
(b) City or town *Downing*
(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 *Entire Life* (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Robert Henry Carter

(b) If veteran, name war *v* Social Security No. *v*

4. Sex *M* Color or race *w*
5. Color or race *w*
6. (a) Single, widowed, married, divorced *married*
(b) Name of husband or wife *Anna Carter*
(c) Age of husband or wife if alive *66* years

7. Birth date of deceased *Sept 16 1868*
(Month) (Day) (Year)

8. AGE: Years *76* Months *2* Days *17*
If less than one day hr. min.

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

10. Usual occupation *Farming*

11. Industry or business

12. Name *Charles Carter*

13. Birthplace *Ohio*
(City, town, or county) (State or foreign country)

14. Maiden name *Martha Shields*

15. Birthplace *Ohio*
(City, town, or county) (State or foreign country)

16. (a) Informant *Anna Carter*

(b) Address *Luray Mo*

17. (a) *Burial* (b) Date thereof *Dec 6-44*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Combs Cemetery Luray Mo*

18. (a) Signature of funeral director *Wm. B. Back*

(b) Address *Memphis Tenn*

19. (a) *Dec 7 1944* (b) *A. Justice*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Clark*
(c) City or town *Luray* 23
(If outside city or town limits, write "RURAL")

(d) Street No. *0* (If rural, give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country *1*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *3*
year *1944* hour *11* minute *30 a.m.*

21. I hereby certify that I attended the deceased from *Dec 2* 19*44*
that I last saw him alive on *Dec 2* 19*44*
and that death occurred on the date and hour stated above.

Immediate cause of death *Myocarditis*

Due to *arterial hypertension and arteriosclerosis*

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations *93%*

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

Where did injury occur? (City or town) (County) (State)

(c) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

(c) Means of injury

23. Signature *Geoff Johnson* (M. D. or other)

Address *Downing Mo* Date signed *12/7/44*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

JAN 6 1945
MAY 4 1945

RECEIVED

District Health Officer No. 10

District File Number 12-44-2086

Date Filed DEC 28 1944

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 Frank Gust

Licensed Embalmer No. 4256

P. O. Address Memphis, Tenn

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.