

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JAN 25 1945

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

104
3770
Do not use this space.

1. PLACE OF DEATH

(a) County Stone Registration District No. 6-16-4346
 (b) Township Pease Primary Registration District No. 34-6616 Registered No. 26
 (c) City 1 (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME William M. Cartner

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice M. Cartner
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13 - 1889
 7. AGE YEARS 53 MONTHS 11 DAYS 16 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sum

FATHER 13. NAME Lewis Cartner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hickman

MOTHER 15. MAIDEN NAME Jennie Reavis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sum

17. INFORMANT (ADDRESS) Alice M. Cartner
Crane, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Crane, Mo DATE 6-23 1945

19. FUNERAL DIRECTOR (NAME) (ADDRESS) George H. Mauldin

20. FILED 6/22 1945 George Mauldin
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-19 1943

22. I HEREBY CERTIFY, That I attended deceased from 1-12- 1942 to 6-19- 1943
 I last saw him alive on 6-19- 1943 Death is said to have occurred on the date stated above, at 11:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Tubercular Peritonitis Date of onset 1942
16
 Other contributory causes of importance: Rheumatic heart disease 1942

Name of operation none Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury T
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify (Signed) H. L. Torr. O., M. D.
 (Address) Crane Mo.

RECEIVED
District Health Officer No. 6;
District File Number 145-96
Date Filed JAN 17 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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.