

FILED MAR 7 1945
Registration District No. 160

Primary Registration District No. 3018

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Salem
(If outside city or town limits, write "RURAL" and name of township)
(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 (Specify whether
In this community most of her life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent 33
(c) City or town rural (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 X

3. (a) PRINT FULL NAME Luvine Carty

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

4. Sex female 5. Color or face W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Vessie Carty 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased March 30 1877 (Month) (Day) (Year)

8. AGE: 67 Years 10 Months 4 Days If less than one day hr. min.

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

10. Usual occupation house wife

11. Industry or business

12. Name W. H. Potter
13. Birthplace Madison Co Mo (City, town, or county) (State or foreign country)
14. Maiden name Terisa Leonard
15. Birthplace Dent Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant *Cherise Carty*
(b) Address Salem Mo

17. (a) Burial (b) Date thereof 2/6/45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Pleasant Cem

18. (a) Signature of funeral director *W. H. Potter*
(b) Address CSalem, Mo

19. (a) 2-5-45 (b) *Joan D. McCarty* (Registrar's signature)
(Data received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4 year 1945 hour 12 minute 45 AM.

21. I hereby certify that I attended the deceased from Feb 6 1945 to Jan 28 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage

Due to: Cardio-vascular disease

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?

23. Signature *L. H. Potter* (M. D. or other) Address Salem Mo Date signed 2/5/45

Duration of illness 1 day
PHYSICIAN Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No 5,

District File Number 345-136

Date Filed 3-5-45-

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..... *Carl D. Johnson*

Licensed Embalmer No 29370

P. O. Address *Palmer*

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.