

FILED FEB 26 1945

Registration District No. _____

Primary Registration District No. **4481**

1. PLACE OF DEATH:

(a) County **Pulaski**
(b) City or town **Dixon, Mo.**
(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 _____ years, months or days)

3. (a) PRINT FULL NAME **Benjamin Franklin Carter**

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

4. Sex **male** 5. Color **white** 6. (a) Single, widowed, married, divorced **widowed**
7. (b) Name of husband or wife **Mary Carter** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **I** **26** **1853**
(Month) (Day) (Year)

8. AGE: Years **92** Months **6** Days **9** If less than one day
hr. _____ min. _____

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

10. Usual occupation **Painter**

11. Industry or business _____

12. Name **John M. Carter**

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

14. Maiden name **Cynthia Lynch** **Tenn.**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Etta Busch**

(b) Address **Dixon Mo.**

17. (a) **Burial** (b) Date thereof **2-6-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dixon, Mo.**

18. (a) Signature of funeral director **H. C. Cunningham**

(b) Address **Vienna, Mo.**

19. (a) **Feb 18-1945** (b) **Chas. W. Codd**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **Feb**
year **1945** hour **10:35** minute **0** M.

21. I hereby certify that I attended the deceased from **Jan 12 - 1945** to **Feb 4 - 1945**
that I last saw him alive on **Feb 4 - 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
of age
Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) _____
(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 **A. J. Greder** (M. D. or other) **O.**
Address **Dixon, Mo.** Date signed **2/4-45**

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.....

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, fact should be so stated above.**