

FILED APR 15 1945

Primary Registration District No. **3010**

Registrar's No. **95**

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 hours
(Specify whether years, months or days)
In this community Since 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Cape Girardeau
(If outside city or town limits, write "RURAL")
(d) Street No. 225 North Spring Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph C. Carpenter

3. (b) If veteran, name war World War # 1 3. (c) Social Security No. 494-16-9472

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Pauline Harris 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 21st 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months 4 Days 8 If less than one day hr. _____ min.

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

10. Usual occupation Public Accountant &

11. Industry or business Auditor

12. Name Conrad Carpenter

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

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pauline Carpenter

(b) Address 5923 W. Lake-Chicago, Illinois

17. (a) Burial (b) Date thereof 3-31-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lorimier Cemetery

18. (a) Signature of funeral director L. L. Heman

(b) Address Cape Girardeau, Missouri

19. (a) 4-4-45 (b) F. W. Phelps
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29th year 1945 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from 2 am March 29 1945 to 8:45 am 3/29 1945
that I last saw him alive on March 29 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pulmonary Congestion Duration 8-10 hrs

Due to Chr. Myocarditis & nephritis 4 yrs

Due to Chr. Alcoholism 4 yrs.

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) _____ (Means of injury)

23. Signature H. J. Oehler (M. D. or other) _____
Address Cape Girardeau Mo Date signed 3/30/45

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

MOTHER FATHER

1014

RECEIVED

District Health Officer No. 4

District File Number 445-47

Date Filed 4-9-45

APR 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..... *Howard B. Plummer*

Licensed Embalmer No. 4122

P. O. Address Cape Girardeau, Missouri

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 53

Primary Registration District No. 3050

Registrar's No. 95

APR 12

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

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau
(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 Joseph C Carpenter

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

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

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

7. Birth date of deceased Nov - 21
(Month) (Day) (Year)

8. AGE: Years 52 Months 4 Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Chr. Pulmonary Angioma
Chr. Myocarditis & Nephritis
Due to Chr. Alcoholism
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy B/E

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 J. G. Decker (M. D. or other) _____
While at work? _____ (Specify type of place) _____
(c) Means of injury _____

Address _____ Date signed _____

SUPPLEMENTARY

FILED

9317