

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 59

FILED JUN 27 1945
Registration District No. 150

Primary Registration District No. 5572

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Prairie Twp
(c) Name of hospital or institution: Jackson County Emergency Hosp
(d) Length of stay: 3 days
In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Fairmount Station K.C. Mo;
(d) Street No. 830 Cedar
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME Charles Everett Carter

3. (b) If veteran, name war none 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Addie Carter 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased January 28 1888

8. AGE: Years 57 Months 3 Days 11 If less than one day hr. _____ min. _____

9. Birthplace Excelsior Springs Missouri

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel H Carter
13. Birthplace North Carolina
14. Maiden name Nancy Jones
15. Birthplace North Carolina

16. (a) Informant Mrs. Addie Carter
(b) Address 830 Cedar

17. (a) Burial & Removal (b) Date thereof 5 10 1945

(c) Place: burial or cremation Nelson Missouri

18. (a) Signature of funeral director Geo. C Carson Funeral Home

(b) Address Independence Missouri

19. (a) May 9-45 (b) F. M. Schell (c) Complete

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8th year 1945 hour 13:00 minute _____

21. I hereby certify that I attended the deceased from May 8th 1945 to May 8th 1945
that I last saw him alive on May 8th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bacterial endocarditis

Due to Hypertensive vascular disease

Due to 9/a

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? _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature Complete (M. D. or other) _____

Address Complete Date signed May 9 1945

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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.