

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33537

State File No.

FILED NOV 8 1945

Registration District No. 23

Primary Registration District No. 2291

Registrar's No. 117

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Liberty
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Odd Fellows Home Liberty
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 3 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. Unknown
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3. (a) PRINT FULL NAME John Clark Carr

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive years 1874

7. Birth date of deceased April 25 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 7 6 hr. min.

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

10. Usual occupation Unknown

11. Industry or business

MOTHER FATHER { 12. Name Ralph Carr
13. Birthplace Unknown Maine
(City, town, or county) (State or foreign country)
14. Maiden name Catherine McDonald
15. Birthplace Unknown Canada
(City, town, or county) (State or foreign country)

16. (a) Informant Superintendent I.O.O.F. Home
(b) Address Liberty, Mo.

17. (a) Removal (b) Date thereof Oct. 31, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland ST. Joe, Mo.

18. (a) Signature of funeral director O.J. Carder Jr.

(b) Address 119 E. Franklin St. Liberty, Mo.

19. (a) Oct 31 1945 (b) Minnie Haynes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 31
year 1945 hour 9 minute 00 A.M.

21. I hereby certify that I attended the deceased from Aug 15 1945 to Oct 31 1945
that I last saw her alive on Oct 31 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion 2 hrs
Coronary thrombosis 5 yrs
Due to Arteriosclerosis Chronic

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

Major findings: Of operations _____
Of autopsy Myo

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) _____
While at work? _____ (e) Means of injury _____

23. Signature Arthur M. Walker M. D. or other M.D.
Address Liberty Mo Date signed 10-31-45

Duration

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. 8,

District File Number _____

Date Filed 11-6-41

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 *O. J. Casper, Jr.*
Licensed Embalmer No. 3934
P. O. Address Liberty, Mo.

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.