

FILED DEC 42 1945

Registration District No. _____

Primary Registration District No. **1000**

Registrar's No. **1219**

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Days
(Specify whether
In this community 1 Month
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa, (b) County Henry
(c) City or town Hillsboro
(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 _____

3. (a) PRINT FULL NAME Loren Rex Carter,

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

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

6. (b) Name of husband or wife Josephine Carter, 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased September 4, 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 2 10 hr. min.

9. Birthplace Hillsboro, Iowa, /
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer,

11. Industry or business _____

MOTHER FATHER { 12. Name John Carter,
13. Birthplace Hillsboro, Iowa, /
(City, town, or county) (State or foreign country)
14. Maiden name Elen Gales,
15. Birthplace Hillsboro, Iowa, /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Josephine Carter,
(b) Address Hillsboro, Iowa,

17. (a) removal (b) Date thereof 11/14/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hillsboro, Iowa,

18. (a) Signature of funeral director W. B. ...

(b) Address 310 So. 10th Street

19. (a) Nov 17 - 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14th
year 1945 hour 2:00 minute 30 PM

21. I hereby certify that I attended the deceased from 10/21/45, 19____, to 11/14/45, 19____;

that I last saw him alive on 11/14/45, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease, arteriosclerotic ?

Due to Arteriosclerosis, general ?

Due to _____

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) (e) Means of injury? _____

23. Signature [Signature] (M. D. or other) _____

Address St. Joseph 8, Mo. Date signed 11/15

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

D. H. M. Castle.
Record Room
no. 1000

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 Frank A. Conway

Licensed Embalmer No. 1710

P. O. Address St. Joseph, 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.