

**FILED DEC 21 1945**  
**STANDARD CERTIFICATE OF DEATH**

State File No. ....

Registration District No. 124

Primary Registration District No. 5459

Registrar's No. ....

**1. PLACE OF DEATH:**

(a) County Circene  
(b) City or town Bois D Arc RFD. 1  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: Sixty Three Years  
In this community Sixty Three Years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Shannon 39  
(c) City or town Bois D Arc RFD.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country: .....

3. (a) PRINT FULL NAME Katherine E. Carter

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

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

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

7. Birth date of deceased: 3 8 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 8 17 hr. min.

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

10. Usual occupation Retired

11. Industry or business: .....

12. Name Aaron Conrad

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

14. Maiden name Elizabeth Sargentfield

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

16. (a) Informant Frank Gates

(b) Address Bois D Arc Mo RFD.

17. (a) Burial (b) Date thereof Nov 26-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prospect Cem

18. (a) Signature of funeral director Morris L. Leitman

(b) Address Ask Grove Mo

19. (a) Nov 30, 45 (b) Geiwell Williams  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 11 day 24  
year 1945 8. hour 9.0 minute P.M.

21. I hereby certify that I attended the deceased from Nov. 20 1945 to Nov 24 1945  
that I last saw h. er alive on Nov. 20 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Mitral Insufficiency 2 yrs

Due to: .....

Due to: .....

Other conditions: Subacute ulcer  
(Include pregnancy within 3 months of death)

Major findings: Of operations: .....

Of autopsy: 92L

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: 0

23. Signature: S. M. Clark (M. D. or other)

Address: Halltown Mo Date signed 11-25-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

9  
0  
6

1295

RECEIVED

Greene County Health Office,

County File Number 45-12-97

Date Filed 12-19-45

---

---

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 Mrs. Maude C. Morris  
Licensed Embalmer No. 2055  
P. O. Address Ash Grove 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.