

No. 2  
-5-43  
-17-39  
X36671

FILED JAN 29 1946  
Registration District No. 77

Primary Registration District No. 3016

State File No. \_\_\_\_\_  
Registrar's No. 18

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Mo. State Penitentiary Hospital 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 yrs. 5 mo.  
(Specify whether years, months or days)

In this community 15 yrs. 11 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26

(c) City or town Jefferson City 5  
(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 Patrick Carter

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21  
year 1946 hour 7 minute 30 AM

21. I hereby certify that I attended the deceased from March  
1945 to January 21, 19 46

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 22 1908  
(Month) (Day) (Year)

that I last saw him alive on January 20, 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Tuberculosis

Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day

37	4	29	hr. min.
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Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation Baker

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy None

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

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? \_\_\_\_\_

16. (a) Informant Hospital records

(b) Address Mo. State Penitentiary

17. (a) Burial (b) Date thereof 1/22/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lynchville School

18. (a) Signature of general director [Signature]

(b) Address Jefferson City, Mo.

19. (a) 1-22-46 (b) R. P. Harris, M.D.  
(Date received) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury [Signature]

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address Jefferson City, Mo. Date signed 1-21-46

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 1-28-46

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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 Victor Buescher  
Licensed Embalmer No. 3701  
P. O. Address Jefferson City, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. FebRegistrar's No. 18Registration District No. 77Primary Registration District No. 3016

## 1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson city  
(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 Patrick Carter3. (b) If veteran,  
name war3. (c) Social Security  
No.4. Sex m5. Color or  
race w6. (a) Single, widowed, married,  
divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if  
alive

7. Birth date of deceased

Aug 22  
(Month) (Day) (Year)1946  
(Year)

8. AGE:

Years

Months

Days

If less than one day

37  
hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (e) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole  
(c) City or town Jefferson City  
(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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Year 1946 hour 7 minute 30 A. M.21. I hereby certify that I attended the deceased from March 20 to Jan 21, 1946  
that I last saw him alive on Jan. 20, 1946  
and that death occurred on the date and hour stated above.Immediate cause of death Bi-lateral  
Tuberculosis of the lungs

Duration

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy noneADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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 W. U. Mcnelly (M.D. or other)Address \_\_\_\_\_ Date signed 1-21-46

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

SUPPLEMENTARY

2490