

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 7 1946

Registration District No. 7

Primary Registration District No. 5638

Registrar's No. 88

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Bates City Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6 mi south west 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 50 yrs
years, months or days

3. (a) PRINT FULL NAME Robert Lee Carpenter
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex m
5. Color or race w
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Jla
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased June 4 - 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 13
If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business Farmer

12. Name John A. Carpenter
13. Birthplace N. Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Mary Longwell
15. Birthplace N. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jla Carpenter

(b) Address Bates City Mo

17. (a) Burial (b) Date thereof 4-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Mo

18. (a) Signature of funeral director W. B. W. W. W.
(b) Address Oak Grove Mo

19. (a) April 29 1946 (b) Letta Drummond
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Bates City Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 6 mi south west
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
year 1946 hour 5:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from February 8, 1943 to April 17, 1946
that I last saw him alive on April 17, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia 2 wks.
Due to Lobar pneumonia 2 wks.

Other conditions Basovary sclerosis 3 yrs.
(Include pregnancy within 3 months of death)

Major findings: OS
Of operations _____
Of autopsy Lobar pneumonia and lobe hypostatic pneumonia

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?

23. Signature R. B. Harker (Specify type of place) _____ (e) Means of injury 2
Address Oak Grove, Mo. Date signed 4-17-46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 5-6-46.....

MAY 27 1946

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..... R B Webb.....

Licensed Embalmer No. 2353.....

P. O. Address Blue Springs 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.

FILED

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 171

Primary Registration District No. (5638)

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Lafayette (Sci-A-Bar)
(b) City or town Bates City "Rural"
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6 mi. south west
(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 Robert Lee Carpenter

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

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

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

7. Birth date of deceased June (Month) 4 (Day) 1946 (Year)

8. AGE: Years 74 Months 10 Days 10 (Unless than one day) hr. min.

9. Birthplace Va (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. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
(c) City or town Bates City "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. 6 mi. south west
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

13717