

FILED JUN 23 1946

4059

Registration District No.

Primary Registration District No.

Registrar's No. 190

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Nellyville
(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 _____ (Specify whether)
In this community 18 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler 12
(c) City or town Nellyville
(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

Joseph Henry Carter

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 Widowed
7. Birth date of deceased: Dec. 17 - 1859
(Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 20 If less than one day hr. min.

9. Birthplace Graves Co. Ky. (City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business Gen. Merchandise

MOTHER FATHER

12. Name Unknown
13. Birthplace Unknown
14. Maiden name Amanda Graves
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elmer Foster
(b) Address Nellyville Mo.

17. (a) Burial (b) Date thereof June 9, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Corning Ark.

18. (a) Signature of funeral director L. D. Russell
(b) Address Corning Ark.

19. (a) 6/15/46 (b) Attorney
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8th. year 1946 hour 3:00 minute _____ A.M.

21. I hereby certify that I attended the deceased from June 6th to June 8th 1946 that I last saw him alive on June 8 and that death occurred on the 8 date and hour stated above.

Immediate cause of death Neurosis of Brain
Due to _____
Due to _____

Other conditions Seizure
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy §301

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 2
23. Signature F. J. Farley (M. D. or other) _____
Address Nellyville Mo. Date signed June 10th 1946

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

RECEIVED

District Health Office No. 2,

District File Number 646-762

Date Filed 6-18-46

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 Leslie D. Russell

Licensed Embalmer No. 3855

P. O. Address Corning, Ark.

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.