

FILED JUL 22 1946  
Registration District No. 274

Primary Registration District No. 3052

State File No.

Registrar's No. 214

## 1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
218 W. 7th St. /  
(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 John Heard Antes

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married,  
divorced Divorced  
6. (b) Name of husband or wife Freda Antes 6. (c) Age of husband or wife if  
alive unknown years  
7. Birth date of deceased January 19, 1874  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 5 16 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Street Decorator

## 11. Industry or business

MOTHER FATHER { 12. Name John F. Antes  
13. Birthplace Harrisburg, Pennsylvania  
(City, town, or county) (State or foreign country)  
14. Maiden name Lucy Jane Dempsey  
15. Birthplace Otterville, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Florence Antes  
(b) Address 218 W. 7th St.

17. (a) Burial (b) Date thereof July 8, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill Cemetery18. (a) Signature of funeral director McLaughlin Bros.(b) Address Sedalia, Missouri

19. (a) 7-12-46 (b) Betty Yeager  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis  
(c) City or town Sedalia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 218 W. 7th St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, day 5th  
year 1946, hour 2.20 P/M, minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from October, 1945  
to Date of death, 19\_\_\_\_, to Date of death, 19\_\_\_\_.

that I last saw him alive on June 26, 1946,  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion InstantDue to Coronary heart disease. One year.Due to XXX

Other conditions No.  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations No, operation.

Of autopsy No autopsy.

## 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) No to all.(b) Date of occurrence XXX(c) Where did injury occur? No injury.  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
No injuryWhile at work? XXX (e) Means of injury XXX23. Signature B. J. Grader (M. D. or other) M.D.Address Sedalia, Mo. July 8, 1946 Date signed

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 7-20-46

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

*K. P. M. Crary*

Licensed Embalmer No. 3153

P. O. Address

*Sedalia M*

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

Aug

Registration District No.

274

Primary Registration District No.

3052

Registrar's No.

2148

## 1. PLACE OF DEATH:

- (a) County Prethia  
(b) City or town Sedalia  
(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 NAMEJohn H. 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
- Divorced

6. (b) Name of husband or wife

Freda

6. (c) Age of husband or wife if
- 
- alive
- 44
- years

7. Birth date of deceased

(Month)

(Day)

(Year)

## 8. AGE:

Years

Months

Days

If less than one day

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. (a) Signature of funeral director

- (b) Address

19. (a) (Date received local registrar)

- (b)
- Betty Yeager

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County

- (c) City or town (If outside city or town limits, write "RURAL")

- (d) Street No. (If rural, give location)

- (e) Citizen of foreign country? (Yes or No)

If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- 1946
- year
- 1946
- hour
- 10
- minute
- 00
- M.

21. I hereby certify that I attended the deceased from
- 1946
- to
- 1946

that I last saw him alive on 1946 and that death occurred on the date and hour stated above.  
Immediate cause of death Heart

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 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 (M. D. or other)

Address Date signed

24553