

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40502

FILED JAN 7, 1947

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 5359

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
General Hospital #1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)
 In this community 25 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County JACKSON 48
 (c) City or town Kansas city 38
(If outside city or town limits, write "RURAL")
 (d) Street No. ST JAMES HOTEL
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 10

3. (a) PRINT FULL NAME ROBERT FRANKLIN CARTER

3. (b) If veteran, name war None 3. (c) Social Security No. Do Not Know

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 3 years
 7. Birth date of deceased MARCH 29 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>8</u>	<u>23</u>	hr. min.

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

10. Usual occupation BONDS MAN

MOTHER FATHER
 11. Industry or business

12. Name William L. Carter

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

14. Maiden name ESTER ELLEN

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

16. (a) Informant Wm L. Carter

(b) Address ST JAMES HOTEL

17. (a) Burial (b) Date thereof DEC 24 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT MORIAH

18. (a) Signature of funeral director PASSANTINO BROS

(b) Address KC, Mo.

19. (a) 12-22-46 (b) Geraldine Holman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 22
 year 1946 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from Dec. 20
1946, to Dec. 22, 19 46
 that I last saw him alive on Dec. 22, 19 46
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to _____
 Due to _____

Other conditions 83 hr
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

Duration

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 0

23. Signature Wm L. Carter (M. D. or other) M.D.
 Address K.C. Mo. Date signed _____

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.....

F. S. Walton

Licensed Embalmer No. 2744

P. O. Address Kansas 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.