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17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 13 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41720**

Registration District No. **200**

Primary Registration District No. **6014**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Higbee Mo Rural  
(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 84yrs 6mo 17da  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Higbee Mo Rural  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME David J Carter

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19  
year 1946 hour 12 minute 20 P.M.

4. Sex Male 5. Color or race White

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

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

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

7. Birth date of deceased June 2 1862  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 19 1946 to Dec 19 1946

that I last saw him alive on Dec 15 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Voluntary Heart

8. AGE: Years 84 Months 6 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

10. Usual occupation Farmer

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

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

MOTHER FATHER { 12. Name Colby Carter

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

14. Maiden name Dont know

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

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

Of autopsy no

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Dewey Carter

(b) Address Higbee Mo

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof Dec 21 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huntsville Mo.

18. (a) Signature of funeral director Joe W Burton  
Higbee Mo.

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. W. Wynn  
(Date received local registrar) (Registrar's signature)

(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 J. W. Wynn (M. D. or other) \_\_\_\_\_  
Address Higbee Mo Date signed 1/20 1947

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

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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 *J. Walker Rudek*  
Licensed Embalmer No. *3336*  
P. O. Address *Glasgow, N.Y.*

**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.**

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

Registration District No. 390 Primary Registration District No. 6014

1. PLACE OF DEATH Randolph Rural  
 (a) County \_\_\_\_\_  
 (b) City or town \_\_\_\_\_  
(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 David J. 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 wid

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

7. Birth date of deceased June 2  
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 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 \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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 \_\_\_\_\_ Day \_\_\_\_\_  
 year \_\_\_\_\_ 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 \_\_\_\_\_

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

PHYSICIAN  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature \_\_\_\_\_ (M. D. or other)  
 Address \_\_\_\_\_ Date signed 11/18/47

SUPPLEMENTARY

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

41720