

FILED AUG 1 / 1947

Registration District No. _____

Primary Registration District No. **3002**

Registrar's No. **113**

1. PLACE OF DEATH:
 (a) County **Audrain**
 (b) City or town **Mexico**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
620 E. Promenade
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **85 yrs**
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Audrain** **4**
 (c) City or town **Mexico** **1**
(If outside city or town limits, write "RURAL")
 (d) Street No. **620 E. Promenade** **2**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME **Claudia Josephine Carter**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **19**
 year **1947** hour **7** minute **20** **A-M.**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**
 6. (b) Name of husband or wife **Alex Carter** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **March 29 1862**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 4** 1947 to **July 18** 1947;
 that I last saw her alive on **July 18** 1947;
 and that death occurred on the date and hour stated above.

8. AGE: Years **85** Months **3** Days **21**
 If less than one day hr. _____ min. _____

Immediate cause of death **Cerebral thrombosis**
 Due to **Menstrual disturbance - Cerebral arteriosclerosis**
 Due to _____

9. Birthplace **Audrain Co., Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Other conditions **B**
(Include pregnancy within 3 months of death)
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name **John G. Wilfley**
13. Birthplace **Va.**
(City, town, or county) (State or foreign country)
14. Maiden name **L. Mervia Smith**
15. Birthplace **Va.**
(City, town, or county) (State or foreign country)

Major findings: **none**
 Of operations: **none**
 Of autopsy: **none**

16. (a) Informant **Mrs Norton Nelson**
(b) Address **Mexico, Missouri.**
17. (a) **Burial** **(b) Date thereof** **July 20, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Elmwood**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **no**
(b) Date of occurrence _____
(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? _____

18. (a) Signature of funeral director **Clara Arnold**
(b) Address **Mexico, Missouri.**
19. (a) **7/20/47** **(b) Blanche Keely**
(Data received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury **0**
23. Signature **Harry F. Oberm** (M. D. or other)
Address **111 E. Main, Mexico, Mo.** **Date signed** **7-20-47**

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

RECEIVED
District Health Officer No. 10
District File Number 7-47-926
Date Filed JUL 30 1947

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 Everett R. Head

Licensed Embalmer No. 4038

P. O. Address Mexico, 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.