

S. No. 2  
1-12-45  
5-17-39  
I X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUL 22 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **26574**  
Registrar's No. **5**

Registration District No. **305** Primary Registration District No. **4239**

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

**1. PLACE OF DEATH:**  
(a) County Washington  
(b) City or town Rural, Bellevue  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1 mile east of Caledonia  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community life  
years, months or days (Specify whether)

**3. (a) PRINT FULL NAME** Levada Elizabeth Carter  
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex fem 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Nicholas Carter 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased October 1 1871  
(Month) (Day) (Year)

**8. AGE:** Years 75 Months 8 Days 10 If less than one day hr. min.

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

10. Usual occupation retired

**MOTHER FATHER**  
11. Industry or business  
12. Name Samuel Hull  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Octavia Taylor  
15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Argie Bridgewater  
(b) Address Bismarck Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 6-13-47 (Month) (Day) (Year)  
(c) Place: burial or cremation Caledonia Mo.

18. (a) Signature of funeral director Norman White & Sons  
(b) Address P. White Ironton Mo.

19. (a) 7. 10 47 (Date received local registrar) (b) Ellen White (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Washington  
(c) City or town Rural (If outside city or town limits, write "RURAL")  
(d) Street No. 1 mile east of Caledonia (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month June day 11 year 1947 hour 8 minute 30 P.M.  
21. I hereby certify that I attended the deceased from June 27, 1947, to July 11, 1947, that I last saw him alive on July 11 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus  
Due to \_\_\_\_\_  
Due to Remedy  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 48B  
Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(c) 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 Jac. W. Hoffmann (M. D. or other) M.D.  
Address Bismarck Date signed 6/14/47

RECEIVED

District Health Officer No. 4  
District File Number 747-946  
Date Filed 7-21-47

---

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 Ruel J. White

License# Embalmer No. 8012

P. O. Address Winton Mass

**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.**