

No. 2
17/47
-17-39

National Office of Vital Statistics
FILED JAN 9 1948 53

Registration District No.

Primary Registration District No. **3010**

Registrar's No.

1. PLACE OF DEATH:

(a) County: **Cape**

(b) City or town: **Cape Girardeau**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Francis Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: **9 weeks**
(Specify whether years, months or days)

In this community: **9 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Mo** (b) County: **New Madrid**

(c) City or town: **Rural, New Madrid**
(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: **RAYMOND CARPENTER**

3. (b) If veteran, name war: **NO**

3. (c) Social Security No.: **NO**

4. Sex: **M** 5. Color or race: **W**

6. (a) Single, widowed, married, divorced: **Single**

6. (b) Name of husband or wife: **None**

6. (c) Age of husband or wife if alive: **None** years

7. Birth date of deceased: **Oct 26 1928**
(Month) (Day) (Year)

8. AGE: Years **19** Months **1** Days **16** If less than one day
..... hr. min.

9. Birthplace: **Clarkton, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Farming**

11. Industry or business: **None**

12. Name: **A. L. Carpenter**

13. Birthplace: **Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name: **Miss Jones**

15. Birthplace: **Clarkton, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Ernest Carpenter**
(b) Address: **New Madrid**

17. (a) **Buried** (b) Date thereof: **Nov 12 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Stouffville, Clarkton, Mo.**

18. (a) Signature of funeral director: **R. J. ...**
(b) Address: **New Madrid, Mo.**

19. (a) **1-3-48** (b) **C. C. SUMMERS**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **12**
year **1947** hour **4** minute **15 P.**M.

21. I hereby certify that I attended the deceased from **10-19** to **12-4** 19**47**
that I last saw him alive on **12-4** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Septicemia**

Due to: **Course undetermined**

Due to:

Other conditions: **Abscesses of liver**
(Include pregnancy within 3 months of death)

Major findings: **None**

Of operations:

Of autopsy: **As above**

PHYSICIAN

Underline the cause of 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? (e) Means of injury: **Auto**

23. Signature: **C. C. Summers** (M. D. or other) **MD**
Address: **New Madrid, Mo.** Date signed: **12/24/47**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4
District File Number 148-31
Date Filed 1-7-48

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 Allen McGowan, Registered Apprentice No. 512, working under my personal supervision.

Signed Leo Hidy
Licensed Embalmer No. 3803
P. O. Address New Market

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.

B
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8890

State File No. Jan

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Capo Girardeau
(b) City or town Capo Girardeau
(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

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 _____

3. (a) PRINT FULL NAME Raymond Carpenter

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 S

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

7. Birth date of deceased 6-26-19
(Month) (Day) (Year)

8. AGE: Years 19 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-13-48 (b) G. C. Summers
(Date received local registrar) (Registrar's signature)

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 _____

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 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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY 2

RECORD
STATE OF MISSOURI
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

41078