

S. No. 2  
M-5-43  
5-17-39  
I X 6671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 13 1948  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **44076**

Registration District No. **270** Primary Registration District No. **6254** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Wayne  
(b) City or town rural Cedar Cr. Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1  
(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 MO. (b) County Wayne  
(c) City or town rural  
(If outside city or town limits, write "RURAL.")  
(d) Street No. near Lake, Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Vesta Carter  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 15  
year 1947 hour 27 minute 45 P.M.  
21. I hereby certify that I attended the deceased from June 14  
1947 to July 15 1947  
that I last saw him alive on July 13 1947  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Andy Carter 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 18 1869  
(Month) (Day) (Year)

Immediate cause of death Malaria  
Duration 1 MO

8. AGE: Years Months Days If less than one day  
77 8 9 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

10. Usual occupation housekeeping

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

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

Of autopsy: \_\_\_\_\_

12. Name John Evans

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

14. Maiden name Eliza Matthews

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

16. (a) Informant Stella Davis

(b) Address Lake, Mo.

17. (a) burial (b) Date thereof July 17 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Antioch Camp

18. (a) Signature of funeral director Samuel W. Dial

(b) Address Antioch Camp

19. (a) Jan. 2, 1948 (b) Glenn E. Thacker  
Date received local registrar (Registrar's signature)

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 O.A. Myers (M. D. or other) \_\_\_\_\_  
Address Caldwells, Mo. Date signed 7/16/47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4  
District File Number 148-44  
Date Filed 1-12-48

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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

Norman W. Fish  
Licensed Embalmer No. 3387

P. O. Address Judson, 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.**