

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 625 N. Weaver St. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 1/2 years  
(Specify whether  
In this community About 50 years  
years, months or days)

3. (a) PRINT FULL NAME Jacob Carter

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 2 / 5. Color or race Col 2 / 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased Unknown (Month) (Day) (Year) 1868

8. AGE: Years 80 Months ? Days ? If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Unknown Arkansas (City, town, or county) (State or foreign country)

10. Usual occupation laborer

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

MOTHER FATHER { 12. Name Neal Carter

13. Birthplace Unknown Arkansas (City, town, or county) (State or foreign country)

14. Maiden name Amer, ea Carter

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

16. (a) Informant Hattie Farris

(b) Address 625 N. Weaver

17. (a) Burial (b) Date thereof 3-19-48 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cem.

18. (a) Signature of funeral director W. P. Campbell

(b) Address 825 Washington Ave.

19. (a) 3-19-48 (b) W. E. Handley, M.D. (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
(c) City or town Springfield 6  
(If outside city or town limits, write "RURAL")  
(d) Street No. 625 N. Weaver 5  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 15 year 1948 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Mar 14 1948, to Mar 15 1948;  
that I last saw him alive on Mar 14 1948; and that death occurred on the date and hour stated above.

Immediate cause of death acute myocardial insufficiency 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 Leman N. Brown (M. D. or other) \_\_\_\_\_

Address 3116 Boonville Date signed Mar 17, 1948

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

9  
2  
b

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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 *W. P. Campbell*

Licensed Embalmer No. *1747*

P. O. Address *Springfield 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.**