

FILED JUN 14 1948

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

18437

State File No. \_\_\_\_\_

Registration District No. 339

Primary Registration District No. 6149

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Asherville, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Duck Creek Twp  
(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 Missouri (b) County Stoddard 113  
(c) City or town Asherville Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Duck Creek Twp 0  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18  
year 1948 hour Three minute 30 P. M.  
21. I hereby certify that I attended the deceased from JAN  
1948 to MAY 17 1948  
that I last saw him alive on MAY 17 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary vascular  
renal disease  
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 JRS Killinger (M. D. or other) \_\_\_\_\_  
Address Prok. MO Date signed May 21/48

3. (a) PRINT FULL NAME Alpha A. Carter,

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 Married

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

7. Birth date of deceased. August 26 1877  
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 22  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Illinois /  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business Farmer

12. Name Bailey Carter,

13. Birthplace Illinois /  
(City, town, or county) (State or foreign country)

14. Maiden name Fiona Barrow,

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

16. (a) Informant Bon Gill

(b) Address Asherville, Mo.

17. (a) Burial (b) Date thereof 5 20 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Hill,

18. (a) Signature of funeral director Watkins Service

(b) Address Puxico Missouri,

19. (a) 5-25-48 (b) Floyd Morgan  
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Office No. 21

District File Number 648-746

Date Filed 6-8-48

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.....

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

Signed *Lyman Steeles*

Licensed Embalmer No. 2476

P. O. Address *Weymouth, 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.