

FILED SEP 7 1948

Registration District No. **100**

Primary Registration District No. **3018**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **DENT**
 (b) City or town **SALEM**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **NONE**
 (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 **DENT** **33**
 (c) City or town **SALEM** **1**
 (If outside city or town limits, write "RURAL") **1**
 (d) Street No. _____ (If rural, give location) **0**
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Lucy L. McCarter**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **W**
 6. (b) Name of husband or wife **BEN McCARTER** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **SEPT. 26 1875**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 10 26 hr. _____ min.

9. Birthplace **MISSOURI**
 (City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER {
 12. Name **ROBERT LAND**
 13. Birthplace **ENGLAND**
 (City, town, or county) (State or foreign country)
 14. Maiden name **LOUISE MANNING**
 15. Birthplace **ENGLAND**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Oliver McCarter**
 (b) Address **SALEM, MISSOURI**

17. (a) **BURIAL** (b) Date thereof **8/23/48**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CEDAR GROVE CEM.**

18. (a) Signature of funeral director **W. T. GENEON**

(b) Address **SALEM, MO.**

19. (a) **Aug 23-48** (b) **M. M. Northrup**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUG** day **21**
 year **1948** hour **11:00** minute **A** M.

21. I hereby certify that I attended the deceased from **May 22**, 19**48** to **Aug 21**, 19**48**
 that I last saw him alive on **Aug 21**, 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of pancreas**
 Due to _____

Other conditions **Cardiac disease - arteriosclerotic**
 (Include pregnancy within 3 months of death)
 Due to _____

Major findings:
 Of operations _____
 Of autopsy **H&E**
 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) (i) Means of injury _____
 23. Signature **M. M. Northrup** (M. D. or other) **MD**
 Address **Salem, Mo.** Date signed **8/23/48**

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

RECEIVED 8-30-48
District Health Officer No. 5,
District File Number 848537
Date Filed 8-31-48

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 Wm W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, Me

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.