

FILED JUN 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14936

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 545

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>12 yrs.</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2638 South 22nd St.</u>		e. STREET ADDRESS (If rural, give location) <u>2638 South 22nd St.</u>	

3. NAME OF DECEASED (Type or Print) <u>FANNIE LEE CARTER</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>May 17, 1954</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 6, 1875</u>	9. AGE (In years last birthday) <u>79</u>	If UNDER 1 YEAR Months _____ Days _____	If UNDER 1 HR. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Plattsburg, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John K. Fry</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Elliott</u>	14. NAME OF HUSBAND OR WIFE <u>Roland H.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Roland H. Carter, 2638 So. 22nd St.,</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION <u>St. Joseph, Mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Failure</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocarditis Chronic</u> DUE TO (c) <u>Hypertension</u>		<u>3 yrs.</u> <u>3 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>443X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 19 50, to May 17, 1954, that I last saw the deceased alive on May 17, 1954, and that death occurred at 5:00P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>M. Allison M.D.</u>	(Degree or title)	23b. ADDRESS <u>Phys &amp; Surg Bldg., City</u>	23c. DATE SIGNED <u>5-19-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 20, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Cameron, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>June 2, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	485-	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bowman</u>	ADDRESS <u>St. Joseph, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *William Spalding*.....

Licensed Embalmer No. 4533

P. O. Address 355 10th St

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.