

FILED APR 30 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12376

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 460

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>Daviess</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>7 yr. 6 mo. 22 da.</u>		c. CITY OR TOWN <u>Hamilton</u>		d. Is Residence within limits of a city or incorporated town? ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2</u>				e. STREET ADDRESS (If rural, give location) <u>not given</u>					
3. NAME OF DECEASED (Type or Print) <u>BLANCH</u>			a. (First)		b. (Middle)		c. (Last) <u>CARTER</u>		
4. DATE OF DEATH <u>April 22, 1956</u>			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>August 24, 1905</u>		9. AGE (In years last birthday) <u>50</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		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>Missouri</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>Frank</u>			
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>Frank Carter, R. R. #3, Hamilton, Mo.</u>					
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Syphilis meningoencephalitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 years</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Syphilis</u>					
				DUE TO (c)					
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						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)					
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?					
22. I hereby certify that I attended the deceased from <u>Jan. 1</u> , 19 <u>56</u> , to <u>April 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>56</u> , and that death occurred at <u>2:35 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Forrest Thomas MD</u>				23b. ADDRESS <u>Attn: Mo 71 Olato Hosp No 2</u>		23c. DATE SIGNED <u>4/22-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>4/27/1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>Apr 27, 1956</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Heston - Brown</u> ADDRESS <u>St. Joseph, Mo</u>				

(Licensed Embalmer's Statement on Reverse Side)

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  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *William Spelling*.....

Licensed Embalmer No. *46*

P. O. Address *719 S. 11th, L.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.