Health, Welfare Public Service

300 -57

FILED AUG 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24453
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3200

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Kansas City — Inside Limits: Yes [#] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Trinity Lutheran — Length of stay in 1b: 60 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes [#] No [ ]
d. STREET ADDRESS (If outside, give location): 510 W. 11th. St. — Reside on Farm: Yes [ ] No [#]

3. NAME OF DECEASED (Type or print): First: Duke — Middle: — Last: Carter

4. DATE OF DEATH: Month: July Day: 9, Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] 3 DIVORCED [#]
8. DATE OF BIRTH: Sept. 7, 1875
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Conductor
10b. KIND OF BUSINESS OR INDUSTRY: K. C. S. Railroad
11. BIRTHPLACE (City and state or country): Bowling Green Kentucky
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: John Carter
13b. MOTHER'S MAIDEN NAME: Mary Elizabeth Gassaway
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 702-12-3138
17. INFORMANT: J. M. Salter — Address: 6157 Holmes K. C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aplastic Anemia — INTERVAL BETWEEN ONSET AND DEATH: 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Bone Marrow Dyscrasia — " "
DUE TO (c): — 2924
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

20a. ACCIDENT [ ] No SUICIDE [ ] No HOMICIDE [ ] No
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from July 1-57 to July 9-57 and last saw her/him alive on July 9-57
Death occurred at 7-9-57 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Dr. C. P. Miller
22b. ADDRESS: 800 Argyle Bldg
22c. DATE SIGNED: 7-10-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7/12/57
23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah
23d. LOCATION (City, town, or county) (State): Kansas City Mo.

24. FUNERAL DIRECTOR — ADDRESS: Stine & McClure K. C. Mo.
25. DATE RECD. BY LOCAL REG.: 7-10-57
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

W. P. Miller M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 M. Turn

Licensed Embalmer No. 4648

P. O. Address Kansas Cit Mo. 6

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.