

Health, & Welfare
Public
Service

FILED DEC 11 1957

STANDARD CERTIFICATE OF DEATH

40847
STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 205

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webb City, Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Rt 4 Carthage, Mo
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 702 N. Tom St.		Length of stay in 1b 5 weeks	d. STREET ADDRESS Rural Rt 4
			Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Walter E. Carter			4. DATE OF DEATH Month Day Year Dec. 3, 1957		
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5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13 1873	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Moberly Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME B.F. Carter	13b. MOTHER'S MAIDEN NAME Viola Ferguson	14. NAME OF HUSBAND OR WIFE Anna Carter
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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) no	16. SOCIAL SECURITY NO. 486-24-5596	17. INFORMANT Mrs. James Hubbard Webb City Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular renal disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } <u>Part II Prostatae hyperplasia, cystitis, pyelitis</u>		<u>-7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Tuberculosis of left radius and ulna</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 8-16-51 to 12-3-57 and last saw ^{her}him alive on 11-30-57.
Death occurred at 6:20 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Am Ferguson</u> (Degree or title) M.D.	22b. ADDRESS Webb City, Mo	22c. DATE SIGNED <u>12/5/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/5/57	23c. NAME OF CEMETERY OR CREMATORY Forrest Park Cemetery	23d. LOCATION (City, town, or county) Joplin Mo.	(State)
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24. FUNERAL DIRECTOR Johnston-Arnce-Simpson Mortuary Webb City, Mo	25. DATE RECD. BY LOCAL REG. 12-5-57	26. REGISTRAR'S SIGNATURE Mrs. Madeline Switzer
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 Harry E. Anne

Licensed Embalmer No. 4463

P. O. Address Wash. City, Mo.

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.