

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012644

AMENDED 042 1000 344 REGISTRAR'S NO. 744 STATE FILE NUMBER

Registration District No. 042
 Primary Registration District No. 1000
 REGISTRAR'S NO. 744
FILED APR 17 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in lb 11 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital		d. STREET ADDRESS (If outside, give location) 2228 No. 3rd Street	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last FRANK E CARTER			4. DATE OF DEATH Month Day Year April 1 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/22/1881	9. AGE (last birthday) 79 years	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Minister		10b. KIND OF BUSINESS OR INDUSTRY Baptist	11. BIRTHPLACE (City and State or country) Coffee, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Othias Carter		13b. MOTHER'S MAIDEN NAME Sarah Dowell		14. NAME OF HUSBAND OR WIFE Estella C. Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			17. INFORMANT Address Mrs. Estella C. Carter, 2228 No. 3rd St. St. Joseph, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure (Intractable)		INTERVAL BETWEEN ONSET AND DEATH 10 days several years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease		
DUE TO (c) Arteriosclerosis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
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
21. I attended the deceased from 1956 to 4-1-61 and last saw her/him alive on 4-1-61		Death occurred at 4:25 A.m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) Lucien W. Ed. M.D.		22b. ADDRESS 902 Edmund - St. Joseph Mo.	22c. DATE SIGNED 4-4-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Entombment	23b. DATE 4/3/61	23c. NAME OF CEMETERY OR CREMATORY Ashland Mausoleum	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
24. FUNERAL DIRECTOR ADDRESS Hamey Funeral Home St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. April 10, 1961	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

L.W. Ed. M.D.

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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph 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.