N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County ~~Dallas~~

Township ~~Washington~~ or Village ~~Hanley~~ or City ..... (NO. ..... St. ..... Ward)

Registration District No. 448 File No. 29580-a

Primary Registration District No. 6608 Registered No. 6

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Arthur Carter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (~~Write the word~~)

6 DATE OF BIRTH: Jan. (Month) 29 (Day) 1902 (Year)

7 AGE: 18 yrs. 8 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country): Dallas Co. Mo

PARENTS

10 NAME OF FATHER: Joseph J. Carter

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Pulaska Co. Mo

12 MAIDEN NAME OF MOTHER: Theodosia Gamer

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dallas Co. Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph J Carter
(Address) Conway Mo

15 Filed 10-5- 1920 O. C. Benage Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 26 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h..... alive on ....., 191.....,
and that death occurred, on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows: 167
Suicide. came to His Death by 38 Pistol Slot Fired by His own Hand (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Lindsey Corn. M. D.
9-26- 1920 (Address) Buffalo, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Gann Cemetery

DATE OF BURIAL: Sept 27, 1920

20 UNDERTAKER: J. H. Moffat

ADDRESS: Conway Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h..... alive on ....., 191.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.