

DEC 26 1928

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

Do not use this space.

205039
70

1. PLACE OF DEATH
 County Newell Registration District No. 382
 Township West Plains Primary Registration District No. 4227
 City West Plains (No.) St. Ward)

2. FULL NAME Benjamin Harrison Carter
 (a) Residence No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No.
 Registered No.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wx 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Ben Carter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 30 1889

7. AGE YEARS MONTHS DAYS LESS than 1 day, hrs. or min.
48 | 40 | 6 | |

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

10. NAME OF FATHER Anderson Carter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Louise Dafferty 6-9-1928 (Address) West Plains Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT (Address) Anderson Carter
West Plains Mo

15. FILED 6-9-28 OPA. Heineke REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/5 1928

17. I HEREBY CERTIFY, That I attended deceased from June 3-1928, to June 5-1928 that I last saw him/her alive on June 4-1928, and that death occurred, on the date stated above, at 11:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fractured Skull
Internal Injuries?
Accidental

(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Wounded Springfield
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No. DATE OF
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None
 (Signed) R.E. Hogan M.D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wounded Springfield DATE OF BURIAL 6/5 1928

20. UNDERTAKER M. Fadlands ADDRESS West Plains Mo

PL 7 L

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- 56
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252

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- 981
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88

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Howell
Township West Plains
City West Plains

Registration District No. 384
Primary Registration District No. 4227

File No. 70
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Benjamin Harrison Carter
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

14. _____

INFORMANT (Address) _____

15. _____

FILED 6-9-28 O.P.A. Heinrich REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-5-28

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Fractured skull
fractured ribs
accidental
fell out of fruit tree.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
_____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, IN INK. THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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