

REC'D MAY 18 1939

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

15262  
Do not use this space.

1. PLACE OF DEATH

(a) County Johnson Registration District No. 437  
(b) Township Rose Hill Primary Registration District No. 5594  
(c) City or Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 35 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Sarah Carter (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 17-1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
76 3 13

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

13. NAME Peter Carter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Mary Wilkerson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Mrs. Frank Snider, Holden Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Holden Cemetery DATE Mar 5 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) T. W. Goodman, Holden Missouri

20. FILED May 5 1939 Anna Coleman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 3, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1939, to Mar 3, 1939.

I last saw him alive on Feb 26, 1939. Death is said to have occurred on the date stated above, at 11:30 A.M.  
The principal cause of death and related causes of importance were as follows:

Myocarditis

A2A1

Date of onset

Other contributory causes of importance;  
Congestive Heart Failure  
Chronic Alcoholism

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_

(Signed) Kelly Rawlins, M. D.  
(Address) Holden Mo.

WRITE PLAINLY, WITH UNFADING 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.

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RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 5/11/39

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *T. J. Goodman*  
Licensed Embalmer No. 2424  
P. O. Address *St. Louis 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 this body is not embalmed, above space should be left blank.**