

Registration District No. 395 Primary Registration District No. 1002 Registrar's No. 4137

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Jackson  
(c) Name of hospital or institution: 3023 Chelea  
(d) Length of stay: In hospital or institution Home  
In this community 20 years

USUAL RESIDENCE OF DECEASED:  
(a) State Mo! (b) County Jackson  
(c) City or town Jackson City  
(d) Street No. 3023 Chelea  
(e) If foreign born, how long in U. S. A. Life years.

3. (a) PRINT FULL NAME Ellen Carpenter  
3. (b) If veteran, name war ✓ 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 28  
year 1939 hour 3 minute 20 a.m.

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Benjamin J. Carpenter 6. (c) Age of husband or wife if alive 42 years  
7. Birth date of deceased Oct - 30 - 1888

21. I hereby certify that I attended the deceased from Jan. - 3, 1936 to Oct 28, 1939  
that I last saw her alive on Aug 1 - 1939  
and that death occurred on the date and hour stated above.

8. AGE: Years 5-0 Months 11 Days 28 If less than one day hr. min.

Immediate cause of death Carcinoma of breast  
secondary anemia  
Due to 510

9. Birthplace Delonia Georgia

Other conditions General Septicemia  
(Include pregnancy within 3 months of death)

10. Usual occupation at home

11. Industry or business at home  
12. Name John Criggle  
13. Birthplace Georgia  
14. Maiden name unknown  
15. Birthplace unknown

Major findings: Of operations None  
Of autopsy None

16. (a) Informant's own signature Bert J. Carpenter  
(b) Address 3023 Chelea

PHYSICIAN  
Underline the cause to which death should be charged statistically.

17. (a) Burial (b) Date thereof 10-30-39  
(c) Place: burial or cremation not known

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director not known  
(b) Address not known

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_

19. (a) 10/29/39 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

23. Signature Ed Rumer (M. D. or other) ✓  
Address 311 Agate St Date signed 10/28-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 I X19311

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.

(Main part)

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

Signed John B. Camp  
Licensed Embalmer No. 2955  
P. O. Address 196 7th

**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.**