

Registration District No. 688

Primary Registration District No. 5916

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Frankford
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location) 7

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike
(c) City or town Frankford
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
year 1940 hour 6 minute 0 P. M.

21. I hereby certify that I attended the deceased from July 6, 1940
that I last saw him alive on July 7, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia - bronch Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. J. Jones (M. D. or other) _____
Address Frankford, Mo Date signed 7/8/40

3. (a) PRINT FULL NAME Louis Carter 636

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Jan 26 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 5 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Salt River near Frankford _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Louis Carter

13. Birthplace Eolia Missouri _____ (State or foreign country)

14. Maiden name Dorothy Miller

15. Birthplace New London Missouri _____ (City, town, or county) (State or foreign country)

16. (a) Informant Louis Carter

(b) Address Frankford Missouri

17. (a) Burial (b) Date thereof July 7 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankford Missouri

18. (a) Signature of funeral director J. J. & Son

(b) Address Frankford Missouri

19. (a) July 20 (b) Mattie Unsee
(Date received local registrar) (Registrar's signature)

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

107a

RECEIVED

District Health Officer No. 10

District File Number 8-40-1558

Date Filed AUG 8 1940

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 Joe Fields Meigow

Licensed Embalmer No. 4093

P. O. Address Frankford, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26021

Registration District No. 688

Primary Registration District No. 5716

Registrar's No. 16

1. PLACE OF DEATH

(a) County Pike
(b) City or town Open - T.I.P.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Louis Carter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. (a) Sex M 5. Color Black 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE	Years	Months	Days	If less than one day
		<u>5</u>	<u>10</u>	hr. min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

(d) Signature of funeral director _____ (e) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month July day 6 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia

Due to No complications

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____

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? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature O.W. Judgrose (M. D. or other) _____ Address Frankford, Mo Date signed 9/15/40

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WHILE MAINLY USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

