

5-17-39
PT X21422

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29779**

AUG 25 1940

790

Primary Registration District No. _____

447

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Slater
(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)

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

In this community Thirty years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Slater
(If outside city or town limits, write "RURAL")

(d) Street No. 918-Grandview Avenue
(If rural, give location)

(e) If foreign born, how long in U. S. A.? Y years.

3. (a) PRINT FULL NAME Charles Pinckney Carr

3. (b) If veteran, name war X

8. (c) Social Security No. A-1566

4. Sex Male

5. Color or race White

6. (a) Single ~~widowed, married, divorced, widowed~~

6. (b) Name of husband or wife X

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased May 29 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 24
If less than one day hr. min.

9. Birthplace Jeffersonville, Clark Co. Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Railroad Car Carpenter

11. Industry or business _____

12. Name John William Carr

13. Birthplace Jeffersonville, Clark Co, Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Jane Amick

15. Birthplace Jeffersonville, Clark Co, Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Bess Carr

(b) Address Slater Mo

17. (a) Burial (b) Date thereof August-24-
(Burial, cremation, or elsewhere) (Month) (Day) (Year)

(c) Place: burial Slater City Cemetery

18. (a) Signature of funeral director Jones & Salzer

(b) Address Slater Mo

19. (a) Aug 24 (b) _____
(Date received by local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23rd
year 1940 hour 8 minute 10 AM

21. I hereby certify that I attended the deceased from Aug. 10
1940, to Aug. 23, 1940
that I last saw him alive on Aug. 23, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Injured in Car accident.

Due to Head injury, causing partial paralysis.

Due to _____

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence aug 10

(c) Where did injury occur? Highway no 5
(City or town) (County) (State)

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

23. Signature A. G. G. Caldwell (M. D. or other) _____
Address Slater Mo. Date signed 8-23-40

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29779**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **799**

Primary Registration District No. **4479**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County. Saline
 (b) City or town. Slater
 (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)
 (d) Length of stay: In hospital or institution. _____
 (Specify whether
 In this community. _____
 years, months or days)

3. (a) PRINT FULL NAME: Charles Pinconey Carr
3. (b) If veteran, name war. _____
3. (c) Social Security No. _____

4. Sex: m **5. Color or** w **6. (a) Single, widowed, married,**
 divorced. wid
6. (b) Name of husband or wife. _____ **6. (c) Age of husband, or wife, if**
 alive. _____ year

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

8. AGE: Years 74 Months 2 Days 24
 If less than one day _____ hr. _____ min.

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

10. Usual occupation. _____

11. Industry or business. _____

12. Name. _____

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

14. Maiden name. _____
 (City, town, or county) (State or foreign country)

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. _____

18. (a) Signature of funeral director. _____

(b) 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 Aug day 23
 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 _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Injured in a car
accident - Non-Collision
Due to Car overturned.
Head injury causing
partial paraplegia

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

Major findings: _____
 Of operations. 7/10/28

Of autopsy. _____

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

(a) Accident, suicide, or homicide (specify): Accident

(b) Date of occurrence: Aug 10 40

(c) Where did injury occur?: Highway No 5-
 (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. _____ (M. D. or other) _____

Address. _____ **Date signed.** _____

SUPPLEMENTAL

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

