

Registration District No. 717

Primary Registration District No. 5946

Registrar's No. _____

1. PLACE OF DEATH

(a) County Putnam

(b) City or town Rural - Medicine Township
(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 65 years
years, months or days)

3. (a) PRINT FULL NAME James Scott Carter

3. (b) If veteran, name war No

3. (c) Social Security No. NO

4. Sex Male race white

5. Color or divorced Widowed

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

6. (b) Name of husband or wife Margaret Carter

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

7. Birth date of deceased January 1 1854
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 31 hr. _____ min. _____

If less than one day

9. Birthplace Vermillion County, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Jerry Carter

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

14. Maiden name Elizabeth Howard

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

16. (a) Informant J. W. Carter

(b) Address Quincy, Mo

17. (a) Rural (b) Date thereof June 25 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spring Cemetery

18. (a) Signature of funeral director Comel. Funeral Home

(b) Address Quincy, Mo

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Putnam

(c) City or town Rural - Medicine Township
(If outside city or town limit, write "RURAL")

(d) Street No. Quincy, Mo
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22
year 1941 hour 6 minute P.M.

21. I hereby certify that I attended the deceased from June 11, 1941, to June 22, 1941,
that I last saw him alive on June 22, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Cystitis Duration 11 days

Due to Prostate Hypertrophy
retention of urine

Due to _____

Other conditions Cancer - Right Side of face 1941
(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 _____

(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? 644
(Specify type of place) _____

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

23. Signature Paul Taylor (M. D. or other) _____
Address Quincy, Mo Date signed 9/23/41

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

600

RECEIVED

District Health Officer No. 10

District File Number 1-41-1345

Date Filed JUL 16 1941

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 W. Comstock

Licensed Embalmer No. 3891

P. O. Address Thonowille 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.

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(a) County Putnam
(b) City or town _____
(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 James Scott Carter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 1 1854
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 25 41 (b) E. Studabaker
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

NEURAL CERTIFICATION

20. DATE OF DEATH Month June day 22
year 1941 hour _____ minute _____ M.

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

Immediate cause of death _____ 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 _____

(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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL COPY

S-22480