

FILED FEB 3 1943 128

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

Registrar's No. 58

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
710 South Robberson  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 710 South Robberson  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19th  
year 1943 hour 4 minute 10A.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 Supposedly a heart failure of some kind—he was dead when I arrived on the scene— I had never seen him before.  
Due to He fell dead in bath room— No suspicion of foul play—I'M sure it was a natural death

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (If) \_\_\_\_\_ (Specify type of place)  
(\*) \_\_\_\_\_ (Specify type of place)

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo Date signed 1, 19, 43

3. (a) PRINT FULL NAME Ed Hill Carter

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

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased: March 13 1868  
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Veterinary

12. Name James Carter

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

14. Maiden name Eliza Jane Stewart

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

16. (a) Informant Mrs. Helen Huckaby

(b) Address 710 South Robberson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

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

(b) Address 1100 Boonville Ave. Spfld, Mo.

19. (a) 19-43 (b) [Signature] (Registrar's signature)

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

MOTHER FATHER

984

39  
6 29

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**

X