

STANDARD CERTIFICATE OF DEATH

State File No. 27265

Registration District No. 149

Primary Registration District No. 102

Registrar's No. 3550

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
General Hospital #2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 day
 (Specify whether
 In this community 44 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1422 Forest Apt. 12--2nd fl.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME CLAYTON CARTER
 3. (b) If veteran, name was World War 3. (c) Social Security No. None

4. Sex Male 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mary Ella Carter
 6. (c) Age of husband or wife if alive 23 years
 7. Birth date of deceased March 4 1887
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 5 7 hr. min.

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Eugene Carter
 13. Birthplace Miami Missouri
 (City, town, or county) (State or foreign country)

14. Maiden name Bell Graves
 15. Birthplace Virginia
 (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Rural (b) Date thereof 8/17/43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highlands

18. (a) Signature of funeral director Watkins Bros.
 (b) Address 1729 Lydia
 19. (a) 8-17-43 (b) P. E. Brown
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 11
 year 1943 hour 11:25 minute P M.

21. I hereby certify that I attended the deceased from August 11 1943 to August 11 1943
 that I last saw him alive on August 11 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute congestive heart failure

Due to Hypertensive type heart disease with decompensation

Due to _____
 Other conditions 93d
 (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?

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

23. Signature H. O. Brown (M. D. or other) MD
 Address Gen. Hosp #2-600 E. 22nd Date signed 8-18-43

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

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

MOTHER FATHER

AUG 26 1943

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 *J. Jerome Maulove*

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.