

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED 'SEP 4 1943
Registration District No. 280

Primary Registration District No. 4418

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Platte Co.

(b) City or town Carden Point
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None

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

(d) Length of stay: In hospital or institution None (Specify whether years, months or days)

In this community 30 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte

(c) City or town Carden Point No.
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME John Browning Carpenter

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Nannie Carpenter

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

7. Birth date of deceased March 25th, 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

63	4	12	hr. min.
----	---	----	----------

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

10. Usual occupation Farrer

11. Industry or business Farming

12. Name William Carpenter

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

14. Maiden name Mollie Kears

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

16. (a) Informant Nannie Carpenter

(b) Address Carden Point, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/1943
(Month) (Day) (Year)

(c) Place: burial or cremation Carden Point Cen.

18. (a) Signature of funeral director Russian Davis

(b) Address Dearborn, Missouri

19. (a) 8/7/1943 (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 7 year 1943 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from July 31 to Aug 7 1943 and that death occurred on the date and hour stated above.

that I last saw him alive on Aug 7 1943

Immediate cause of death Myocarditis

Duration one week

Due to _____

Due to _____

Other conditions 93e1
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no

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. A. Moore (M. D. or other)

Address Dearborn Mo Date signed Aug 7/43

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

RECEIVED

District Health Officer No. Platt
District File Number 9-43-81
Date Filed 9-2-43

Handwritten notes:
M.H. in
of 1943
paid
in 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 Reuben Davis
Licensed Embalmer No. 4168
P. O. Address Seaborn 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 280

Primary Registration District No. 4418

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Cambden Point
(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 John Browning Carpenter

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 m

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

7. Birth date of deceased mar 25 19
(Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days _____
If less than one day _____ 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 _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) (Mrs) Clay Liffie
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
to _____ 19____

that I have seen him 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

SUPPLEMENTARY

29081