

Registration District No. **147**

Primary Registration District No. **1602**

Registrar's No. **566**

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:
401 West 43rd Terrace /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **18 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Bettie Carter**
3. (b) If veteran, name war **None** **3. (c) Social Security No.** **None**

4. Sex **Fe** **5. Color or race** **Col** **6. (a) Single, widowed, married, divorced** **Widowed**
6. (b) Name of husband or wife **Chas. Carter** **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **November 11, 1864**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	2	16	_____ hr. _____ min.

9. Birthplace **Alabama** (City, town, or county) (State or foreign country)
10. Usual occupation **At Home**

MOTHER FATHER

11. Industry or business _____
12. Name **Jabe Dawson**
13. Birthplace **Macon Georgia** (City, town, or county) (State or foreign country)
14. Maiden name **Amanda**
15. Birthplace **Georgia** (City, town, or county) (State or foreign country)

16. (a) Informant **Harrietta Moody**
(b) Address **401 West 43rd Terr.**

17. (a) burial (Burial, cremation, or removal) **(b) Date thereof** **2-5-45** (Month) (Day) (Year)
(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **Stathins Bros.**
(b) Address **1729 Lydia**

19. (a) 2-5-45 (Date received local registrar) **(b) D. E. Brown** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** **(b) County** **Jackson** **48**
(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")
(d) Street No. **401 West 43rd Terr.** **8**
(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 **27th**
 year **1945** hour **3:05** minute **P.** M.
21. I hereby certify that I attended the deceased from **1-25** 19**45** to **1-27** 19**45**
 that I last saw h. **er** alive on **1-27** 19**45**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Lobay Pneumonia,** **2 days**
Due to **General Debility.**

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

Major findings: **108**
 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 **J. O. Herley** (M. D. or other)
Address **1663 E. 18th St.** **Date signed** **2-5-45**

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

J. O. Henley,

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. J. Manlove
.....
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.