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5-17-39  
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FILED JUN 7 1945  
Registration District No. 270

Primary Registration District No. 5947

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH

(a) County Phelps

(b) City or town St James Mo  
(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 name and location)

(d) Length of stay: In hospital or institution 5 Soldiers Home  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Harold a Carter

3. (b) If veteran, name war World war no 1

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

7. Birth date of deceased 1 18 1884  
(Month) (Day) (Year)

8. AGE: Years 61 Months 4 Days 7

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Don't know

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 Soldiers Home records

(b) Address St James Mo

17. (a) Bureau (b) Date thereof 5-28-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Delcious Mo

18. (a) Signature of funeral director Wm J. Tucker

(b) Address St James Mo

19. (a) 5-26-1945 (b) Chauncie Dickson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

(c) City or town St James Mo  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 25  
year 1945 hour 10 minute 45 P M.

21. I hereby certify that I attended the deceased from April 15 to May 25, 1945  
that I last saw him alive on May 25, 1945  
and that death occurred on the date and hour stated above

Immediate cause of death Myocarditis

Due to Chronic alcoholism 10 yrs

Due to \_\_\_\_\_

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

PHYSICIAN

Major findings: Chronic

Of operations \_\_\_\_\_

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

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? \_\_\_\_\_

23. Signature William Tucker (M. D. or other) \_\_\_\_\_

Address St James Mo Date signed 5/26/45

227  
-45

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.....

*me*

....., Registered Apprentice No.....

working under my personal supervision.

JUN 8 1945

Signed

*Oral E. Schliker*

Licensed Embalmer No.

*3544*

P.O. Address

*St James 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. June  
Registrar's No. \_\_\_\_\_

Registration District No. 276

Primary Registration District No. 5947

1. PLACE OF DEATH:

(a) County Phelps  
(b) City or town St James Miss.  
(If outside city or town limits, with "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 Harold A. 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 Single

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

7. Birth date of deceased Jan 15 (Month) (Day) (Year)

8. AGE: Years 61 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mass (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) 6-14-1945 (b) Charlie Dickson  
(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 Mar Day 25  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

17810