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40722

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 413-

FILED JAN 15 1946
Registration District No. 4/57

Primary Registration District No. 3008

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

1. PLACE OF DEATH: Callaway
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 8 W. 7th St.
(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 Callaway
(c) City or town Fulton
(If outside city or town limits, write "RURAL")
(d) Street No. 8 W. 7th St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM CARTER
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 28
year 1945 hour 6 minute 0 A. M.

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

21. I hereby certify that I attended the deceased from 12-28-45 to 12-28-45 that I was called and that death occurred on the date and hour stated above. Immediate cause of death Death probably due to chronic myocarditis Duration _____

7. Birth date of deceased Sept. 25 1870
(Month) (Day) (Year)
8. AGE: Years 75 Months 3 Days 0 If less than one day _____ hr. _____ min.

Due to chronic myocarditis
Due suffered for some time

9. Birthplace DK ILL 1
(City, town or county) (State or foreign country)

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

10. Usual occupation Retired Farmer
11. Industry or business _____
12. Name Robert G. Carter
13. Birthplace DK 9
(City, town or county) (State or foreign country)
14. Maiden name DK
15. Birthplace DK
(City, town or county) (State or foreign country)

Major findings: Of operations 930
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Mayme Leatherman
(b) Address Pleasant Hill, Mo
17. (a) Burial (b) Date thereof Dec. 27, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fulton, Mo
18. (a) Signature of funeral director Jim Y. Maupin
(b) Address 712 Court St. Fulton, Mo.
19. (a) 12-27-1945 (b) Joyce M. Mauer
(Date received local registrar) (Registrar's signature)

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 3
23. Signature W. J. Ferratt (M. D. or other) _____
Address Fulton, Mo Date signed 12-27-45

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142
x

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 1-14-46

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 Glen Y. Manzi

Licensed Embalmer No. 2725

P. O. Address Fulton, 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. 40722
Registrar's No. 410-

Registration District No. 47 Primary Registration District No. 2008

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(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 William 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 Sept 2 1946
(Month) (Day) (Year)

8. AGE: Years 75 Months _____ 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. (c) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Glenn Y. Mays

(b) Address _____

19. (a) 2-27-1946 (b) Josie Mosekoff
(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 1946 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 _____

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)

(c) 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 _____

