

FILED MAR 27 1946
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 237

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burge Hospital
(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 Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 2152 Taylor Ave.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Frank Carter

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 Widower

6. (b) Name of husband or wife W.K. 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased March 15, 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 25
If less than one day hr. _____ min. _____

9. Birthplace Webster Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Employee Springfield Mo.

11. Industry or business City Street Department

12. Name John D. Carter

13. Birthplace W.K. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mary McMurtrey

15. Birthplace W.K. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Florice Carter

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 3-11-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burge Hospital

18. (a) Signature of funeral director J. W. Lingner & Co.

(b) Address Springfield, Mo.

19. (a) 3-11-46 (b) J. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1946 hour 8 minute 55 A.M.

21. I hereby certify that I attended the deceased from Jan 1945 to March 20 1946
that I last saw him alive on March 8 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery Disease
Due to Arteriosclerosis

Due to _____
Other conditions (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) (e) Means of injury _____

23. Signature W. D. Delaney (M. D. or other) MD
Address Springfield, Mo. Date signed 3/11/46

39
2
6
7985
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

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. B. Klingner*
3358
Licensed Embalmer No.....
P. O. Address..... *Springfield, 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.