No. -5-43
-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUN 12 1946

State File No. 16294

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 454

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: 1711 West Chestnut (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 3 Months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright 114

(c) City or town Mtn. Grove (If outside city or town limits, write "RURAL")

(d) Street No. unknown (If rural, give location) 1 0

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country No

3. (a) PRINT FULL NAME NANCY JANE CARTER

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife JERRY L. CARTER

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

7. Birth date of deceased JUNE (Month) 11 (Day) 1872 (Year)

8. AGE: Years 73 Months 11 Days 14 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Nash
13. Birthplace Unknown UNK (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace UNK UNK (City, town, or county) (State or foreign country)

16. (a) Informant Jerry L. Carter
(b) Address Mtn. Grove, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/46 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Grove Mo.

18. (a) Signature of funeral director Russell Barber
(b) Address Mtn. Grove Mo.

19. (a) 5-28-46 (Date received local registrar) (b) D. W. E. Sandling (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 25 year 1946 hour 5:45 minute P. M.

21. I hereby certify that I attended the deceased from 3-3- 1946 to 5-25- 1946 that I last saw her alive on 5-18- 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of R Lung	4 mo
Due to Carcinoma of Lt. Breast	
Due to	
Other conditions: Senility (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. E. Feller (M. D. or other)

Address Springfield Mo. Date signed 5/28/46

111

(Licensed Embalmer's Statement on Reverse Side)

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 R. W. Barber

Licensed Embalmer No. 3848

P. O. Address Mtn. Home

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.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 454

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:

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

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

3. (a) PRINT FULL NAME Nancy J. Carter

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 June 11 1873
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 5 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer Left Nipple — Duration

Due to

Due to

Other conditions 50
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature C E Feller (M. D., or other)
Address Springfield Mo Date signed 1-14-42

SUPPLEMENTARY

15781

16294