

FILED JUL 8 1946

State File No. \_\_\_\_\_

Registration District No. 124

Primary Registration District No. 5459

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

## 1. PLACE OF DEATH

(a) County Greene  
 (b) City or town Rural x Centerburg  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 50 yrs years, months or days

3. (a) PRINT FULL NAME Ella Carter

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Andrew Jackson Carter 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 7, 1890 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 11 17 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name Thornton B. Jones

13. Birthplace \_\_\_\_\_ (City, town or county) (State or foreign country)

14. Maiden name Fannie Estelle Jones

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Lee Carter(b) Address Bois d'Arc17. (a) Burial (b) Date thereof 1946 (City or town) (County) (State) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director [Signature](b) Address [Address]19. (a) June 28-46 (b) Jewell Williams (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 39  
 (c) City or town Rural x (If outside city or town limits, write "RURAL") 0  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 0  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24  
 year 1946 hour 8:20 minute P M.

21. I hereby certify that I attended the deceased from June 22, 1946, to June 24, 1946, that I last saw her alive on June 24, 1946, and that death occurred on the date and hour stated above.

## Immediate cause of death

Carcinoma of liver

## Duration

4 months

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

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

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings:

Of operations noneOf autopsy none

## 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 023. Signature S.M. Clark M.D. (M. D. or other) 0Address Hall town Mo Date signed 6-25-46

Oscar Carroll  
Windsor R.I.

RECEIVED

Greene County Health Office,

County File Number 467-78

Date Filed 7-3-44

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 

Licensed Embalmer No. 903

P. O. Address Windsor R.I.

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. July

Registration District No. 124

Primary Registration District No. ~~5954~~ 5459

Registrar's No. J

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2nd Center  
(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 Ella 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 wid

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

7. Birth date of deceased: July (Month) 1946 (Year)

8. AGE: Years 75 Months 11 Days 19 (Less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ 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. (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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene  
(c) City or town Rural  
(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)

(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 \_\_\_\_\_

SUPPLEMENTARY



20036