

No. 2  
-12-45  
-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUN 11 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**18045**

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

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 43

**1. PLACE OF DEATH**

(a) County Linn

(b) City or town Brookfield  
(If outside city or town limits write "RURAL" and name of township)

(c) Name of hospital or institution: 118 Penn Ave 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 3 years (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Linn 58

(c) City or town Brookfield 1  
(If outside city or town limits, write "RURAL.")

(d) Street No. 118 Penn Ave 2  
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country \_\_\_\_\_

**3. (c) PRINT FULL NAME** MARGARET PRESTON CARTER

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 29  
year 1947 hour \_\_\_\_\_ minute 3 P M

21. I hereby certify that I attended the deceased from 10-1-46  
1946 to 5-29 1947

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex F 1 5. Color or race W

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

6. (b) Name of husband or wife Thomas A. Carter 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Jan - 9 - 1881  
(Month) (Day) (Year)

Immediate cause of death Acute Myocardial Infarct Duration 1 hr

Due to Arterio-sclerosis + hyper-tension 10 yrs

Due to Chronic Int. Septic 10 yrs

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

8. AGE: Years 66 Months 4 Days 20 If less than one day hr. min.

9. Birthplace D.K. Scotland  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Stearns 4

13. Birthplace D.K. Scotland  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Walker

15. Birthplace D.K. Scotland  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Thomas A. Carter

(b) Address Brookfield Mo

17. (a) Removal (b) Date thereof May-31-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookwood Ill

18. (a) Signature of funeral director Hill Funeral Home

(b) Address Brookfield Mo

19. (a) 5/30/47 (b) Walter Blinn  
(Date received local registrar) (Registrar's signature) 1/27

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 2

23. Signature W. B. Smith MD (M. D. or other) 5/30

Address Brookfield Mo Date signed 5/30

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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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. H. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address.....

*Brookfield 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.