

12-45
-17-39
X47070

FILED OCT 28 1947

Registration District No. **360**

Primary Registration District No. **3076**

Registrar's No. **138**

1. PLACE OF DEATH:

(a) County **Vernon**
(b) City or town **Nevada**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Nevada Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **two weeks**
(Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Vernon** ¹⁰⁸
(c) City or town **Nevada**
(If outside city or town limits, write "RURAL")
(d) Street No. **730 N. Spring Street** ²⁰
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Frank Perry Carrier**

3. (b) If father, name was **no** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **31** year **1947** hour **8:30** minute **P** M.

21. I hereby certify that I attended the deceased from **Aug 31**, 1947, to **Oct 14**, 1947, and that I last saw him alive on **Oct 14**, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer Prostate**
Due to **Don't Know**

Other conditions **Chr Nephritis & Cholecystitis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **None**
Of autopsy **None**

Duration **Several years.**
one or two years.
PHYSICIAN
Underline the cause to which death should be charged statistically.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Nethie May Carrier** 6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **Dec 16 1876**
(Month) (Day) (Year)

8. AGE: Years **70** Months **9** Days **28** hr. min.

9. Birthplace **Woodbine Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business

12. Name **Edwin C Carrier**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** ⁹
(City, town, or county) (State or foreign country)

16. (a) Informant **Clifford E. Carrier**

(b) Address **Capadenton, Mo.**

17. (a) **Burial** (b) Date thereof **10 16 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Newton Burial Park**

18. (a) Signature of funeral director **Allen J. Ray**

(b) Address **Nevada, Mo.**

19. (a) **10-24-47** (b) **Kathryn Yancy**
(Date received local registrar) (Registrar's signature) **331**

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?

(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. B. ...** (M. D. or other) **MD**

Address **Nevada, Mo** Date signed **Oct 12/47**

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

MOTHER FATHER

RECEIVED
DIVISION OF HEALTH CONTROL NO. 7
10-27-47
9-47-1241

100

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 Allen S. Kaye
Licensed Embalmer No. 1968
P. O. Address Nevada 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.