

FILED JUL 22 1948

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23044

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2899

1. PLACE OF DEATH  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wheatley Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
In this community 21 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Harry Carter  
3. (b) If veteran, name war World War I 3. (c) Social Security No. unknown

4. Sex M 2. Color or race Col 5. Color or race Col  
6. (a) Single, widowed, married, divorced, Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Dec. (Month) 11 (Day) 1898 (Year)

8. AGE: Years 49 Months 6 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation laborer

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

12. Name Joseph Carter

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

14. Maiden name Mary

15. Birthplace unk. Va. (City, town, or county) (State or foreign country)

16. (a) Informant Willetta Mentor  
(b) Address 819 E. 24th

17. (a) Burial (b) Date thereof 7-15-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheatley Cem.  
18. (a) Signature of funeral director Adkins Bros.  
(b) Address 2000 E. 12th St. K.C. Mo.

19. (a) 7-14-48 (b) Stearns Holms  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 819 E. 24th  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 10th  
year 1948 hour 9 minute 15 P. M.  
21. I hereby certify that I attended the deceased from 7-7-48 to 7-10-48  
that I last saw her alive on 7-10-48  
and that death occurred on the date and hour stated above.

Immediate cause of death: Address  
of cerebral  
Due to: Paul  
Due to: \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: none  
Of operations: \_\_\_\_\_  
Of autopsy: as above

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)  
Means of injury: \_\_\_\_\_  
Signature: [Signature] (M. D. or other)  
Address: 1433 E 19th Date: 7/12/48

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

MOTHER FATHER

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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 *Renneth Reynolds*

Licensed Embalmer No. 4477

P. O. Address *H. P. White*

**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.**