

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19047

State File No. ....

FILED JUN 20 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 98 PRIMARY REG. DIST. NO. 5358 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution - residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Colfax Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Colfax Twp</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF (If not in hospital of institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>William McKinley</u> b. (Middle) <u>Carter</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>6 6 1949</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-26-1896</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Holden Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Wm. Carter</u>	13b. MOTHER'S MAIDEN NAME <u>Faimes</u>	14. NAME OF HUSBAND OR WIFE <u>Louville Carter</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes World War 1</u>	16. SOCIAL SECURITY NO. <u>500-0967</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Karl Green</u>	ADDRESS <u>Winston Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 6, 1949, to June 6, 1949, that I last saw the deceased alive on June 6, 1949, and that death occurred at 6:30 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Fred Wilson MD</u>	23b. ADDRESS <u>Winston Mo</u>	23c. DATE SIGNED <u>Jan 7-49</u>
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24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6-8-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lathrop</u>	24d. LOCATION (City, town, or county) (State) <u>MO</u>
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DATE REC'D BY LOCAL REG. <u>11th June 1949</u>	REGISTRAR'S SIGNATURE <u>Vigueria M Englehardt</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs Kate Shoup</u>	ADDRESS <u>Winston Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 8 1949

**DISTRICT HEALTH OFFICE**  
**Camden, Mo.**

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_

Signed.....  
Student Embalmer

Licensed Embalmer No. 3307

P.O. Address Gallatin, 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.