

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

151

State File No.

No. 300
10.48

FILED FEB 2 1950

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 16

| | | | | | | | |
|--|--|--|---|---|--|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u> c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sanford's Convalescent Home</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Boone</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u> d. STREET ADDRESS (If rural, give location) <u>507 Clay</u> | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Sallie</u> b. (Middle) _____ c. (Last) <u>Carter</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 23, 1950</u> | | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>April 8, 1880</u> | 9. AGE (In years last birthday) <u>70</u> <u>69</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, except if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Boone County</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Charles Wilbert</u> | | 13b. MOTHER'S MAIDEN NAME <u>Laura Gray</u> | | 14. NAME OF HUSBAND OR WIFE <u>Dave Carter (deceased)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>~</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Edna Monroe</u> | | ADDRESS <u>112 Switzler</u> | | | |
| 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. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Heart disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Paralysis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>4500</u> | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>T</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>_____ Boone County Mo</u> | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>_____</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from <u>1-13</u>, 19<u>50</u>, to <u>1-13</u>, 19<u>50</u>, that I last saw the deceased alive on <u>1-13</u>, 19<u>50</u>, and that death occurred at <u>12:30</u> p.m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>F. B. Williamson M.D.</u> | | | 23b. ADDRESS <u>22 N. 8th Columbia Mo</u> | | 23c. DATE SIGNED <u>1-24-50</u> | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Jan 25, 1950</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Log Providence</u> | 24d. LOCATION (City, town, or county) (State) <u>Boone County Mo</u> | | | | |
| DATE REC'D BY LOCAL REG. <u>Jan 27 1950</u> | REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Louise E. Huff</u> | | ADDRESS <u>608 Park</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

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

104
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RECEIVED JAN 30 1950
District Health Officer No. 9,
District File Number

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Leonard E. Hoff

Licensed Embalmer No. 4660

P. O. Address 320 N. Carth

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.