

FILED JUL 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22746**

BIRTH NO. _____		REG. DIST. NO. 38		PRIMARY REG. DIST. NO. 3006		Registrar's No. 291	
1. PLACE OF DEATH a. COUNTY Boone b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia c. LENGTH OF STAY (In this place) 9 days d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Ellis Fischel State Cancer Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pottis c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia 0804 d. STREET ADDRESS (If rural, give location) 609 W Cooper St.			
3. NAME OF DECEASED (Type or Print) a. (First) LORENE b. (Middle) MATTIE c. (Last) CARTER		4. DATE OF DEATH (Month) (Day) (Year) July 14 1950		5. SEX 3 FEMALE		6. COLOR OR RACE NEGRO	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 11-4-1900		9. AGE (In years last birthday) 49 If under 1 year: Months 8 Days 10 If under 28 hrs: Hours 10 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Willard, Missouri		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William Rollins	
13b. MOTHER'S MAIDEN NAME Matilda Rollins		14. NAME OF HUSBAND OR WIFE Lucius A. Carter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Cancer Hospital Record		17. ADDRESS Cancer Hospital Record		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Chronic myeloid leukemia		INTERVAL BETWEEN ONSET AND DEATH 1yr	
18. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
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 7-10 , 1950, to 7-14 , 1950, that I last saw the deceased alive on 7-14 , 1950, and that death occurred at 10⁵⁷P m., from the causes and on the date stated above.		23a. SIGNATURE (Degree or title) Richard E. Johnson, M.D.	
23b. ADDRESS Columbia, Mo		23c. DATE SIGNED 7-14-50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 17, 1950	
24c. NAME OF CEMETERY OR CREMATORY Crown Hill Annex Cemetery		24d. LOCATION (City, town, or county) (State) Sedalia, Mo.		DATE REC'D BY LOCAL REG. July 15 1950		REGISTRAR'S SIGNATURE Mrs. R.E. Palmer	
25. FUNERAL DIRECTOR'S SIGNATURE Ernie Cloward		ADDRESS Sedalia Mo.		(Licensed Embalmer's Statement on Reverse Side)			

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

0109

RECEIVED
DISTRICT HEAD OFFICE
District File Number _____
Date Filed 7-18-5

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 Johnnie A. [Signature]

Licensed Embalmer No. 4245

P. O. Address Seelaha 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.