

FILED AUG 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24018

State File No. _____

Registrar's No. 24

BIRTH NO. _____		REG. DIST. NO. <u>207</u>		PRIMARY REG. DIST. NO. <u>5756</u>		State File No. _____		Registrar's No. <u>24</u>		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).						
a. COUNTY <u>Maries</u>				a. STATE <u>Missouri</u>		b. COUNTY <u>Maries</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>High Gate</u>			c. LENGTH OF STAY (In this place) <u>2 Yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) _____						
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) <u>High Gate</u>						
3. NAME OF DECEASED (Type or Print)			a. (First) <u>Robert</u>	b. (Middle) <u>Lee</u>		c. (Last) <u>Carter</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 24, 1950</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 4, 1873</u>		9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Lorenzo Carter</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Murland</u>			14. NAME OF HUSBAND OR WIFE <u>May Carter</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Oma Spencer</u>				ADDRESS <u>Inola, Oklahoma.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH		
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>						<u>30 MIN.</u>		
		ANTECEDENT CAUSES								
		<p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p>								
		DUE TO (b) <u>Angina Pectoris</u>						<u>1 Yr.</u>		
		DUE TO (c) _____								
		II. OTHER SIGNIFICANT CONDITIONS								
		<p>Conditions contributing to the death but not related to the disease or condition causing death.</p>						<u>4 1/2</u>		
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 <u>2/7, 1950</u> , to <u>7/24, 1950</u> , that I last saw the deceased alive on <u>7/22, 1950</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above.										
23a. SIGNATURE <u>R. A. Schowalski, D.O.</u>				23b. ADDRESS <u>Belle, Mo</u>			23c. DATE SIGNED <u>7/28/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-26-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Timpson Chapel</u>			24d. LOCATION (City, town, or county) (State) <u>Oklahoma</u>				
DATE REC'D BY LOCAL REG. <u>8-2-50</u>		REGISTRAR'S SIGNATURE <u>Pauline Howard</u>			198		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>O. E. Lickliger, St. James</u>			

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

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File No. _____
DISTRICT HEALTH OFFICE No. 4

AUG - 8 1950

RECEIVED

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 _____

----- Me -----

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed Carl J. Glenn

Licensed Embalmer No. 4707

P. O. Address St. James, Missouri.

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.