

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED OCT 6 1950

State File No. **29710**

BIRTH NO. _____ REG. DIST. NO. **386** PRIMARY REG. DIST. NO. **5-199** Registrar's No. **12**

1. PLACE OF DEATH a. COUNTY Carroll.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Carroll.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bogard VAN HORN RURAL.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bogard, VAN HORN. 0170	
c. LENGTH OF STAY (in this place) 50 years.		d. STREET ADDRESS (If rural, give location) Rural. Bogard, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION No.			

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) EDGAR c. (Last) CARTER			4. DATE OF DEATH (Month) (Day) (Year) SEPT 29 1950.		
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH July 7-1862	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Days 2 IF UNDER 24 HRS. Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER.		10b. KIND OF BUSINESS OR INDUSTRY ✓	11. BIRTHPLACE (State or foreign country) Ky. /		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME WILLIAM Carter	13b. MOTHER'S MAIDEN NAME Lucie Haggard	14. NAME OF HUSBAND OR WIFE Effie RUSSELL.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME Christine Carter ADDRESS Bogard, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis (acute)		INTERVAL BETWEEN ONSET AND DEATH 30 min
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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?

22. I hereby certify that I attended the deceased from **March 24, 1949**, to **Sept 29, 1950** that I last saw the deceased alive on **Sept 23, 1950**, and that death occurred at **5 A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Douglas Kelling M.D.	23b. ADDRESS Waverly Mo	23c. DATE SIGNED 9-30-50
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE OCT-1-1950	24c. NAME OF CEMETERY OR CREMATORY OAK HILL
24d. LOCATION (City, town, or county) (State) Carrollton Mo.		

DATE REC'D BY LOCAL REG. 9-30-50	REGISTRAR'S SIGNATURE Eunice Street 48	25. FUNERAL DIRECTOR'S SIGNATURE E.A. Dickerson ADDRESS Bogard, Mo.
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A.S. (Licensed Embalmer's Statement on Reverse Side)

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



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.....

E. Dukerson

Licensed Embalmer No.

2534

P. O. Address.....

Bogard M

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.