

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7988

State File No. _____

FILED MAR 17 1952

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 247	
1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE Mo b. COUNTY Wheeler			
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Seymour		1120	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Springfield Baptist Hospital				d. STREET ADDRESS (If rural, give location) Mo			
3. NAME OF DECEASED (Type or Print) a. (First) EUGENE b. (Middle) PAUL c. (Last) CARTER			4. DATE OF DEATH (Month) (Day) (Year) 3-9-1952				
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED 3	8. DATE OF BIRTH 2-19-1909	9. AGE (In years last birthday) 43	MONTHS 0	DAYS 20	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MERCHANT		11. BIRTHPLACE (State or foreign country) WEDSTON CO MO		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME C. J. CARTER			13b. MOTHER'S MAIDEN NAME ELIZABETH		14. NAME OF HUSBAND OR WIFE -		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Eugene P. Carter		ADDRESS Seymour 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis					INTERVAL BETWEEN ONSET AND DEATH 450	
	ANTECEDENT CAUSES DUE TO (b) Ca. of tongue & mouth						
	DUE TO (c) mouth						
	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 141X				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 Jan 1952 , to 3/9 , 1952, that I last saw the deceased alive on 3/8 , 1952, and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE Ray H. Callaway MD				23b. ADDRESS Springfield		23c. DATE SIGNED 3/9/52	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 3-11-52	24c. NAME OF CEMETERY OR CREMATORY Seymour		24d. LOCATION (City, town, or county) (State) Wheeler Co. Mo		
DATE REC'D BY LOCAL REG. 3-10-52		REGISTRAR'S SIGNATURE James R. Amos, M.D.		FUNERAL DIRECTOR'S SIGNATURE Kelly Farrell Bergman		ADDRESS Seymour Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

1396

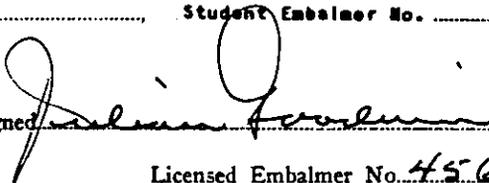
STATEMENT BY LICENSED EMBALMER

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.

Signed _____



Signed _____
Student Embalmer

Licensed Embalmer No. 4568

P. O. Address Springfield 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.