

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013214

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1692

|   |                               |   |   |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>                   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Kansas City</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                               | c. CITY OR TOWN <u>Greenridge</u> <u>6800</u><br>Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                          |   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Lukes</u>   |                               | Length of stay in lb <u>3 weeks</u>   |   |
| d. STREET ADDRESS <u>Rt. 1-</u>   |                               | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>Homer</u> Middle <u>E.</u> Last <u>Carter</u>   |                               |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>3</u> Year <u>1959</u>                              |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-20-91</u>   |
| 9. AGE (In years last birthday) <u>68</u>   |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Farmer</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Blainetown Mo</u>                                |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                               | 13a. FATHER'S NAME<br><u>William Carter</u>   | 13b. MOTHER'S MAIDEN NAME<br><u>Eddie Kurtley</u>   |
| 14. NAME OF HUSBAND OR WIFE<br><u>Bessie Carter</u>   |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No, or unknown) (If yes, give year or dates of service)<br><u>No</u>                                  |   |
| 16. SOCIAL SECURITY NO.<br><u>489-42-5482</u>   |                               | 17. INFORMANT<br><u>Ma Bessie Carter</u> Address <u>Greenridge Mo</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>  |                               |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 YRS</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. }<br>DUE TO (b) _____<br>DUE TO (c) _____  |                               |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                               |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><u>4200</u>   |   |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____   |                               |   |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                               | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 20f. CITY, TOWN, OR LOCATION  |                               | COUNTY STATE  |   |
| 21. I attended the deceased from <u>1949</u> and last saw her alive on <u>3 APR 59</u><br>Death occurred at <u>12:15</u> A. M. on the date stated above; and to the best of my knowledge, from the causes stated. |                               |   |   |
| 22a. SIGNATURE<br><u>John F. Mc Donnell, M.D.</u> (Degree or title)   |                               | 22b. ADDRESS <u>315 Nichols Road</u><br><u>KANSAS CITY 12 MISSOURI</u>  |   |
| 22c. DATE SIGNED<br><u>3 APR 59</u>   |                               |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                               | 23b. DATE   |   |
| <u>Removal</u>  |                               | <u>April 3, 1959</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY  |                               | 23d. LOCATION (City, town, or county) (State)   |   |
| <u>Greenridge Cemetery</u>  |                               | <u>Greenridge Missouri</u>  |   |
| 24. FUNERAL DIRECTOR ADDRESS  |                               | 25. DATE RECD. BY LOCAL REG.  |   |
| <u>Herbert Funeral Home Greenridge Mo</u>   |                               | <u>4-5-59</u>   |   |
| 26. REGISTRAR'S SIGNATURE<br><u>Neva Marshall</u>   |                               |   |   |

Health, Welfare, Public Service

300  
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

John F. Mc Donnell

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 .....  
Signature of Student Embalmer

Signed *Chas E. Welch* .....

Licensed Embalmer No. *2644* .....  
P. O. Address *He 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.