

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-047718

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 217 Primary Registration District No. 5787 Registrar's No. 2

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 9 1962

VS 300  
Rev. 4/59

1 0670

2 0670

3

4 3

5 1

6

7 1

8 0

9 7954

10

11

12 90-8

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>		Length of stay in 1b <b>3 yrs.</b>	c. CITY OR TOWN <b>Charleston</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 2</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 2, Box 317</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Lee</b> Last <b>Carter</b>			4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>49</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. BIRTHPLACE (City and state or country) <b>Walls, Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Wash Robinson</b>		13b. MOTHER'S MAIDEN NAME <b>Louise McCay</b>	14. NAME OF HUSBAND OR WIFE <b>Sam Carter</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Sam Carter, R. 2, Box 317, Charleston, MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Presumed to be natural causes</b> DUE TO (b) <b>Coroner of Miss. Co. notified.</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her alive on _____ Death occurred _____ <b>4:00</b> _____ <b>A.</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dee or title) <b>Local Registrar</b>		22b. ADDRESS <b>Charleston Mo</b>	22c. DATE SIGNED <b>12-28-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/28/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>
		23d. LOCATION (City, town, or county) <b>Charleston, Missouri</b>	(State)
24. FUNERAL DIRECTOR <b>L. R. Sparks</b>		ADDRESS <b>Charleston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-28-62</b>
		26. REGISTRAR'S SIGNATURE <b>Dorothy B. Hathorn</b>	

Permit issued  
12-28-62  
877

**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 James A. Carter  
Licensed Embalmer No. 4681

P. O. Address W. Lee Mc...

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.