S. No. 2
M—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 14 1945

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

24798
State File No.

Registration District No. 297 Primary Registration District No. 4447 Registrar's No. 49

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

1. PLACE OF DEATH:
(a) County: Ray
(b) City or town: Henretta , Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: None. In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Ray
(c) City or town: Henrietta , Mo. (If outside city or town limits, write "RURAL") Rural
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: U.S.A.

3. (a) PRINT FULL NAME: PERCILLAR CARTER
3. (b) If veteran, name war: NO
3. (c) Social Security No.: NO
4. Sex: Female
5. Color or race: Black
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: John Carter , Deceased
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Oct. 14 th. 1861. (Month) (Day) (Year)
8. AGE: Years 83, Months 9, Days 18. If less than one day: hr. min.
9. Birthplace: Morton , Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Housekeeper.
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace: " (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Unknown
15. Birthplace: " (City, town, or county) (State or foreign country)
16. (a) Informant: Clinton Carter
(b) Address: Henrietta , Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-3-45. (Month) (Day) (Year)
(c) Place: burial or cremation: Richmond , Mo.
18. (a) Signature of funeral director: Brothers & Olivert F.H.
(b) Address: Richmond , Mo.
19. (a) Aug 2 45 (Date received local registrar) (b) Mrs Chas W Sheppard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1 st. year 1945. hour 11 minute 30 A. M.
21. I hereby certify that I attended the deceased from July 24, 1945 to Aug 1, 1945; that I last saw her alive on July 28, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis — Duration
Due to: Cerebral Hemorrhage
Due to:
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations — Of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature: E. E. Fay (M. D. or other)
Address: Richmond Date signed: 8-2-45

1280

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-13-45

## 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 ..............................

.............................................................., Registered Apprentice No..............................,

working under my personal supervision.

Brothers - Quest Funeral Home
Signed Louis Quest 4096.
Licensed Embalmer No.
Richmond, Mo.
P. O. Address

**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.**