WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31099

PLACE OF DEATH

County Ray

Township Richmond — Registration District No. 744 — File No.

or

Village —

or

City — (No. —, — St.; — Ward)

Primary Registration District No. 5976B — Registered No. 853

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Guinten Cater

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH: Feb (Month) 6 (Day) 1838 (Year)

AGE: 81 yrs. 8 mos. 14 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Mo

PARENTS

NAME OF FATHER: Jacob Cater

BIRTHPLACE OF FATHER (City or town, State or foreign country): North Carolina

MAIDEN NAME OF MOTHER: Elizabeth Lowery

BIRTHPLACE OF MOTHER (City or town, State or foreign country): East Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L Lucinda Cater

(ADDRESS) Richmond Mo

Filed Oct 25, 1919 R. L. Hamilton REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

DATE OF DEATH: October (Month) 24 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1919, to Oct. 24, 1919, that I last saw him alive on Oct. 23, 1919, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

41 10 40

(Duration) 1 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. B. Cook M. D.

10-24 1919 (Address) Rayville, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? —

Former or usual residence —

PLACE OF BURIAL OR REMOVAL: Todds Chapel — DATE OF BURIAL: Oct 26 1919

UNDERTAKER: J. E. Broadhurst — ADDRESS: Rayville

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....(NO.....St.:.....Ward)

MISSOURI STATE BOARD OF HEA
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[If death occu
hospital or in
give its NAME
of street and nu

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month).....(Day), 1.....(Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....,
(Month).....(Day)

I HEREBY CERTIFY, that I attended deceased
....., 191....., to.....,
that I last saw h.....alive on.....,
and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....mos.

Contributory
(SECONDARY).....

.....t.....(Duration).....yrs.....mos.

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Cause (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	**ADDRESS**

Vast improvement, and its scope can be extended at a later date. With respect to the cause of death, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD