

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

Do not use this space.

20186

1. PLACE OF DEATH

County *Moniteau*
Township
City *Linton* (No. _____ St. _____ Ward _____)

Registration District No. *575*
Primary Registration District No. *4339*

File No. _____
Registered No. _____

2. FULL NAME

Charles Brooking Carpenter

(a) Residence, No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Martha Carpenter*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *2-24-1852*
7. AGE YEARS *80* MONTHS *3* DAYS *20* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Farmer*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) *6-14-32* 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

13. NAME *Jacob S. Carpenter*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

15. MAIDEN NAME *Jane Carpenter*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

17. INFORMANT (ADDRESS) *Mrs. Char. Carpenter Linton Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *S.O.F. Linton* DATE *6-16-1932*

19. UNDERTAKER (ADDRESS) *Jewell E. Richards Linton Mo.*

20. FILED *June 15, 1932 Mrs. Sarah Freye Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 14, 1932*

22. I HEREBY CERTIFY That I attended deceased from *June 14, 1932* to *June 14, 1932*
I last saw h. _____ alive on *June 14, 1932*. Death is said to have occurred on the date stated above, at *6:00 P.M.*

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
J. J. W.
Other contributory causes of importance: *None*
Date of onset _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *None*
If so, specify _____

(Signed) *S. H. Reed*, M. D.
(Address) *Tipton, Mo.*

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.

JUN 25 1932

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