

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

Do not use this space.

28970

**1. PLACE OF DEATH**

County..... Registration District No. 78  
 Township..... Primary Registration District No. 22  
 City St. Louis (No. St. Lukes Hospital St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_  
 Registered No. 8078

**2. FULL NAME**

(a) Residence. No. 4415 Pershing Ave 19 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 Elfie Thomas Carr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt. 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
abt. 54 Unknown

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work. Automobile Salesman  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) St. Louis  
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER O. Bent Carr

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis  
 (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Louisa Atchinson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis  
 (STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. Elfie T. Carr  
 (Address) 4415 Pershing Ave

15. FILED May 19 1929 Max C. Starck REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-3 1929

17. I HEREBY CERTIFY, That I attended deceased from July 29 1929 to Aug 3 1929 that I last saw him alive on Aug 3 1929 and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

54  
Brain Tumor non Malignant (duration) yrs. 6 mos. 0 ds.  
 CONTRIBUTORY (SECONDARY) Shock from glucose injection (duration) yrs. 10 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) Richard B. Clifford M. D.

Aug 5 1929 (Address) Bourbon Bldg.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bellefontaine Cemetery DATE OF BURIAL 8-6 1929  
 ADDRESS 3846 Lindell Blvd.

20. UNDERTAKER Arthur J. Donnelly

WRITE PAINLY, 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.

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Dr. Henry  
all. 11

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Je 5600

Je 5440

Dr. Al'ans