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

Do not use this space.

34846

OCT 24 1934

Registration District No. 1123

Primary Registration District No. 624803.

File No.

Registered No. 335

1. PLACE OF DEATH

County St. Louis

Township Carondelet

City Jefferson Barracks, Mo. (No. Veterans' Administration Facility, St. Ward)

2. FULL NAME Jacob M. CARTER

(a) Residence, No. 1015 Main Str., Venice, Ills. 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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) November 11, 1887

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
46	10	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Shoemaker

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Unavailable

10. Date deceased last worked at this occupation (month and year) Unavailable

11. Total time (years) spent in this occupation Unavailable

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wauson Florida

FATHER

13. NAME Joseph Carter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unavailable Florida

MOTHER

15. MAIDEN NAME Susan Sapp

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unavailable Florida

17. INFORMANT C. H. SMITH, M.D., Clinical Director
(ADDRESS) Vets. Adm. Fac., Jeff. Bks., Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Madison Ill. DATE Sept 20 1934

19. UNDERTAKER Francis Lahey
(ADDRESS) Madison Ill.

20. FILED 9-20, 1934 [signature] M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 20, 1934

22. I HEREBY CERTIFY, That I attended deceased from September 15, 1934 to September 20, 1934

I last saw him alive on September 20, 1934. Death is said to have occurred on the date stated above, at 11:30 A.M.

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

	Date of onset
Hemorrhage due to Gastric Ulcer	Unkn.
117A	
103B	

Other contributory causes of importance: None

Name of operation Transfusion Date of 9-20-34

What test confirmed diagnosis? History, course, laboratory findings Was there an autopsy? No

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?

If so, specify

(Signed) W. O. GIBSON, M.D., Manager, M.D.

(Address) Vets. Adm. Fac., Jeff. Bks., Mo.