

REC'D APR 11 1938

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

 9235
 Do not use this space.

1. PLACE OF DEATH

 (a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **City Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
Registered No. **2824**2. PRINT FULL NAME **Jay Wroy Carson 625**
 (a) Residence, No. **2119 Bremen** St. **26**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Anna May**

 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Anna May**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Oct. 19, 1873**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 5 5

 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. **Clerk**
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not known**FATHER 13. NAME **John W. Carson**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **not known**MOTHER 15. MAIDEN NAME **Beth Dodge**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **not known**17. INFORMANT **Frank Power**
(ADDRESS) **4833 Hamburg**

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Calvary** DATE **March 28, 38**19. FUNERAL DIRECTOR **John L. Ziegenhein & Son**
(ADDRESS) **7027 n Gravois Ave.**20. FILED **MAR 25 1938**
J. D. Budick
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **March 24, 1938**
 22. I HEREBY CERTIFY, That I attended deceased from **3/18/38 -**, 19, to **3/24/38 -**, 19...

 I last saw him alive on **3/24**, 19**38** Death is said to have occurred on the date stated above, at **4:15** p.m.

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

Cerebral thrombosis ✓
Hypertensive heart disease

Date of onset

Other contributory causes of importance:

Generalized arteriosclerosis

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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) **D. W. Maxwell**, M. D.(Address) **1515 Lafayette**

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by *myself.*

.....L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.

Signed *Clarence P. Kidwell*
Licensed Embalmer No. *3877*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

9238
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 791

(b) Township _____ Primary Registration District No. 1003 Registered No. 2824

(c) City St. Louis (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St.

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

2. PRINT FULL NAME Jay Wray Carson

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

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

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

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

64 5 5

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

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

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

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED JUL 5 1938 J. F. Brudick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Date of onset _____

Other contributory causes of importance: _____

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? _____

If so, specify _____

(Signed) R. W. Maxwell, M. D.

(Address) 15-15 Lafayette

SUPPLEMENTARY

IF SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COR. ED. BY LAW.

