DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34005

1939 NOV 13 791

Registration District No. 1003

Primary Registration District No.

Registrar's No. 8543

1. PLACE OF DEATH:

(a) County 1

(b) City or town St Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether years, months or days)

In this community 25 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

17

(d) Street No. 2330 Arkansas
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Cull, Carrie Elizabeth

3. (b) If veteran, name war ----

3. (c) Social Security No. ----

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Albert B. Cull

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Jan. (Month) 11 (Day) 1886 (Year)

8. AGE: Years 53 | Months 8 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace (City, town, or county) Alabama (State or foreign country)

10. Usual occupation Home

11. Industry or business

MOTHER FATHER

12. Name Unknown

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A B Cull

(b) Address 2330 Arkansas

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/7/39 (Month) (Day) (Year)

(c) Place: burial or cremation Up. Crematory

18. (a) Signature of funeral director Wacker-Toelle

(b) Address 2331 S. Broadway

19. (a) OCT 5 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3 year 1939 hour 11 minute 28 P.M.

21. I hereby certify that I attended the deceased from October 1, 1939, to October 3, 1939; that I last saw her alive on October 3, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhage & Cachexia	
Due to: Carcinoma of Thyroid	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Gene B Sterlaff M.D. (M. D. or other)

Address Barnes Hospital Date signed 10/9/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2. 50M-5-17-39 Rev. 5-17-39 1 X19511

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Frank J Nyland Jr.

Licensed Embalmer No. 9645

P. O. Address St Louis Mo

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

If this body is not embalmed, above space should be left blank.