

FILED FEB 7 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3729

94

Registration District No. 784

Primary Registration District No. 200

Registrar's No.

1. PLACE OF DEATH:

- (a) County St. Louis
- (b) City or town Koch
- (c) Name of hospital or institution: Robert Koch Hospital
(If outside city or town limits, write "RURAL" and name of township)
- (d) Length of stay: In hospital or institution 710 days
(If not in hospital or institution, write street number or location)
- In this community Same
years, months or days (Specify whether)

8. (a) PRINT FULL NAME WILLIAM LORENZO CARR8. (b) If veteran, name war NONE 8. (c) Social Security No. None

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Mae Anderson 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased February 25 1894
(Month) (Day) (Year)

8. AGE: Years 45 Months 10 Days 16 If less than one day hr. min.9. Birthplace Streator Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Chiropractor11. Industry or business Chiroprody

12. Name William A Carr
13. Birthplace Streator Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Cora M Patterson
15. Birthplace Streator Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Deceased
- (b) Address 2414 Montgomery St
17. (a) Burial (b) Date thereof 1 17 40
(Burial, cremation, or removal) (Month) (Day) (Year)
- (c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director J. Richardson
- (b) Address 2625 Washington St
19. (a) 1-15-40 (b) R. M. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County _____
- (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
- (d) Street No. 2523A Glasgow (North)
(If rural, give location)
- (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11
year 1940 hour 3 minute 00 A. M.21. I hereby certify that I attended the deceased from July 1 1939, to Jan 11 1940;
that I last saw him alive on Jan 10 1940;
and that death occurred on the date and hour stated above.Immediate cause of death Chronic pulmonary tuberculosis Duration 3 yrsDue to Fatal pulmonary hemorrhageDue to _____
Other conditions (include pregnancy within 3 months of death) [Signature]Major findings: Of operations _____
Of autopsy Refused

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Clyde R. [Signature] (M. D. or other) [Signature]
Address Koch Hospital, Koch, Mo Date signed 1-13-40

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

A. J. Franchard

Licensed Embalmer No.

2928

P. O. Address

2625 Glasgow

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.