

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

Rev. 5-17-39
1 x1511

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.

APR 1 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9470
Registrar's No. 2953

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(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:
City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 Days (Specify whether
In this community 35 yrs. years, months or days)

8. (a) PRINT FULL NAME Walter Carpenter

8. (b) If veteran, name war Unknown 8. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased August 7, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>7</u>	<u>11</u>	_____ hr. _____ min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER { 12. Name James Carpenter

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 Ann [Signature]

(b) Address City Hospital, #1

17. (a) _____ (b) Date thereof 7/26/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. [Signature]

(b) Address 3500 Rutger

19. (a) MAR 29 1940 (b) J. T. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 807 Salisbury
(If rural, give location)
(e) If foreign born, how long in U. S. A. No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18,
year 1940 hour 3:05 minute P. M.

21. I hereby certify that I attended the deceased from March
5, 1940, to March 18, 1940;
that I last saw h. im. alive on March 18, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration _____

Due to Antemortem years

Due to _____

Other conditions (Include pregnancy within 3 months of death) [Signature]

Major findings: Of operations _____

Of autopsy _____

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 W. Ford (M. D. or other) _____
Address 1515 Lafayette Date signed 3/19/40

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.