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FILED **MAY 15 1940** 791
Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2725 Stoddard, St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME **Carrie Little** **340**

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

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Andrew Little** 6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **September 20 1898**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	41	7	0	hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Gilbert McDaniel** **G**

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

{ 14. Maiden name **Becky Joiner**

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

16. (a) Informant **Andrew Little**
(b) Address **2725 Stoddard St.**

17. (a) **Burial** (b) Date thereof **4-28-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **G. L. Barber**
(b) Address **2829 Washington, Ave.**

19. (a) **APR 27 1940** (b) **J. B. Rudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **21**
(If outside city or town limits, write "RURAL")
(d) Street No. **2725 Stoddard, St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **20th**
year **1940** hour **2 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **May 1st** 19**36**, to **Apr. 20th** 19**40**
that I last saw her alive on **4-20-** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis**
5-28-40

Due to **Nephritis Chronic** **5-7x**

Due to _____

Other conditions **Bronchial Asthma** **5-4x**
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

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 **E. J. ...** (M. D. or other)
Address **3532 Washington, Ark.** Date signed **4/24/40**

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 Arthur L. Holliday

Licensed Embalmer No. 3389

P. O. Address 7028 Dickson

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.