

Registration District No. **791**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County _____

(b) City or town Saint Louis ²
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6109 Pennsylvania
(If not in hospital or institution, write street number, or location)

(d) Length of stay: In hospital or institution _____
Unavailable (Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Frances Carter ⁶³⁶

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Samuel Carter

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

7. Birth date of deceased February 14, 1856
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>2</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace Mineral Point, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Unavailable - Smith

13. Birthplace Mineral Point Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unavailable

15. Birthplace Mineral Point Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Willard C. Carter

(b) Address 6109 Pennsylvania Avenue

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 5/6/1940
(Month) (Day) (Year)

(c) Place: burial or cremation Park Dale Cemetery

18. (a) Signature of funeral director Chas. G. Sales

(b) Address 4107 Finney Avenue

19. (a) MAY 6 1940 (Date of local registration)

(b) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town Saint Louis, Missouri ¹
(If outside city or town limits, write "RURAL")

(d) Street No. 6109 Pennsylvania
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2,
year 1940 hour 9 minute 25 P. M.

21. I hereby certify that I attended the deceased from Dec
December 1st, 1939 to May 2, 1940
that I last saw her alive on May 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Haemorrhage ^{3 days}

Due to Arterio-sclerotic heart
disease with chronic nephritis --about 1 yr.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN [Signature]

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) (r) Means of injury _____

23. Signature William D. Johnson (M. D. or other) _____
Address 3100 Lucas Avenue Date signed _____

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.

1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025

STATEMENT BY LICENSED EMBALMER

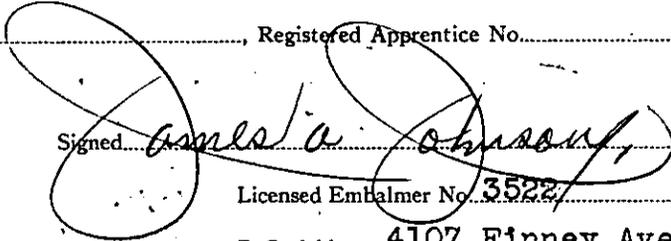
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

Registered Apprentice No.....

working under my personal supervision.

Signed.....



James A. Johnson

Licensed Embalmer No. **3522**

P. O. Address **4107 Finney Avenue**

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.