

FILED JUN 15 1940 791 E

Registration District No. 1003

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 917 Kentucky Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6th
year 1940 hour 9:15 minute A.

21. I hereby certify that I attended the deceased from 2-28, 1940, to 5-6, 1940
that I last saw her alive on 5-5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary Thrombosis Duration 1 day

Due to Hypertensive Cardio Vas. Disease
Due to 2 small

Other conditions
(Include pregnancy within 3 months of death)

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? _____

23. Signature Carl J. Rere (Specify type of place) (e) Means of injury _____
Address 304 Washington (M. D. or other) _____
Date signed 5-7-40

8. (a) PRINT FULL NAME Nora Theresa Carter 636

8. (b) If veteran, name war None 3. (c) Social Security No. 497-23-036

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

6. (b) Name of husband or wife William J. Carter 6. (c) Age of husband or wife if alive About 64

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

8. AGE: Years Months Days If less than one day
About 54 hr. min.

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

10. Usual occupation Seamstress

11. Industry or business Gale & Rosenbaum

12. Name Michael Daly

18. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Garesche

16. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant William G. Carter
(b) Address 917 Kentucky Ave.

17. (a) Burial (b) Date thereof 5-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshausner Montuar
(b) Address 4228 So. Kingshighway

19. (a) MAY 7 1940 (b) J. F. Brodbeck
(Date received local registrar) (Registrar's Signature)

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

MOTHER FATHER

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

5

2-4 3804 Woodbury Ave

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 Edwin M. Bernate

Licensed Embalmer No. 3021

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.