

Registration District **91** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **2808 Walnut St**  
(d) Length of stay: In hospital or institution **20y**  
In this community **20y**

3. (a) PRINT FULL NAME **Luella Carrington**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **Col.**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **H. Carrington** 6. (c) Age of husband or wife if alive **60** years  
7. Birth date of deceased **July 19 1889**

8. AGE: Years **51** Months **2** Days **2**  
If less than one day hr. min.

9. Birthplace **Fulton Ark**

10. Usual occupation **Housewife**

11. Industry or business **At Home**

MOTHER FATHER  
12. Name **Unknown**  
13. Birthplace **Unknown**  
14. Maiden name **Charity Waffer**  
15. Birthplace **Ark.**

16. (a) Informant's own signature **C.H. Carrington**  
(b) Address **2408 Walnut**

17. (a) **Burial** (b) Date thereof **9-27-40**  
(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Medowell**  
(b) Address **3506 Franklin Ave**

19. (a) **SEP 25 1940** (b) **J.F. [Signature]**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MO** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(d) Street No. **2808 Walnut St**  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **20** year **1940** hour **12** minute **40** A. M.

21. I hereby certify that I attended the deceased from **9/17** 19**40** to **9/21** 19**40**  
that I last saw **her** alive on **9/21** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy**  
Due to **Hypertension**

Other conditions **Hypertension**  
Major findings: **No**  
Of operations **No**  
Of autopsy **No**

Duration **4 Days**  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature **[Signature]** (M. D. or other) \_\_\_\_\_  
Address **[Signature]** 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.

**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.....

William C. McDowell, Registered Apprentice No. ....  
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

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;**