No. 2
1-10-39
-17-39 -
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33739

FILED NOV 16 1940

Registration District No. 7911

Primary Registration District No. 1003

Registrar's No. 8436

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 13 days (Specify whether years, months or days)
In this community 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits write "RURAL")

(d) Street No. 2018 Kraft
(If rural, give location)

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

3. (a) PRINT FULL NAME Harry Cartwright

3. (b) If veteran, name war No.

3. (c) Social Security No. 497-16-9814

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Norma Rae

6. (c) Age of husband or wife if alive 18 years

7. Birth date of deceased Oct. (Month) 12, (Day) 1916 (Year)

8. AGE: Years 23 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Franklin Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Grinder Steel Foundry

11. Industry or business

MOTHER FATHER

12. Name John Cartwright

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

14. Maiden name Nan Bowles

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

16. (a) Informant M. E. Barry

(b) Address 5600 Arsenal st.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-11-40 (Month) (Day) (Year)

(c) Place: burial or cremation St. Clair, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) OCT 11 1940 (Date received local registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10/ day 10/10
year hour 12:10 P. Minute M.

21. I hereby certify that I attended the deceased from 9/27/40, 19, to 10/10/40, 19; that I last saw him alive on 10/10/40, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Diphtheria, Pharyngeal	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Myocarditis Diphtheria	
Major findings of operations:	
Of autopsy: None	

PHYSICIAN

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 None

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Bert Bozarth, M. D. (M. D. or other)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Guy W Wilkerson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.