No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34161

FILED NOV 16 1940

Registration District No. 791 | Primary Registration District No. 1003 | Registrar's No. 8858

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2227 Cass Ave. 2
(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 Missouri (b) County
(c) City or town St. Louis 20
(If outside city or town limits write "RURAL")
(d) Street No. 2227 Cass Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Rhoda Carter

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 Single

6. (b) Name of husband or wife ----

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

7. Birth date of deceased Unavailable (Month) Abt. (Day) 1869 (Year)

8. AGE: Years	Months	Days	If less than one day
Abt 71	--	--	hr. min.

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

10. Usual occupation House work

11. Industry or business

MOTHER
12. Name Granville Carter
13. Birthplace Unavailable (City, town, or county) Unavailable (State or foreign country)

FATHER
14. Maiden name Elizabeth Tyler
15. Birthplace Unavailable (City, town, or county) Unavailable (State or foreign country)

16. (a) Informant Rachel Hurt
(b) Address 2227 Cass Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/40 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. States
(b) Address 4107 Finney Ave.

19. (a) OCT 28 1940 (Date received local registrar) (b) J. H. Bardach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25th year 1940 hour 2:35 minute P.M. M.

21. I hereby certify that I attended the deceased from August 15th, 1940 to October 25th, 1940 that I last saw her alive on Oct. 25th, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Hemeplagia, caused	71 days
Due to by cerebral hemorrhage	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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) NO
(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) Means of injury ----

23. Signature J. L. Fulda (M. D. or other) M.D.
Address 2601a Dickson St. Date signed 10/26/40

(Licensed Embalmer's Statement on Reverse Side)

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

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 James A Dawson

Licensed Embalmer No.....

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.