

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

36722

Registrar's No.

8995

Registration District No.

791

Primary Registration District 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: In street at First & Spruce
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)
In this community 2

3. (a) PRINT FULL NAME

Alonzo Carter

8. (b) If veteran, name war

8. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 1882 years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

abt 58

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

Edgar Sutherland

(b) Address

4987 Schollmeyer

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

St. Louis

18. (a) Signature of funeral director

W. R. R. R.

(b) Address

3500 Rutledge

19. (a)

(Date received location of death)

NOV 1 1940

(b) (Signature of informant)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. Mo Home (If rural, give location)
(e) If foreign born, how long in U. S. A. Physician years
MEDICAL CERTIFICATION
Found dead Oct 5
20. DATE OF DEATH: Month Oct day 5
year 1940 hour 5 minute 55 P. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Chronic Myocarditis
Chronic Parenchymatous Nephritis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 121
Major findings: Of operations _____
Of autopsy _____

Duration

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 _____
(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)

(a) Means of injury

23. Signature

Alfred Perry (M. D. or other)

Address

St. Louis

Date signed 9/14/40

(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.....

Licensed Embalmer No.....

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.