

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **9157**

FILED DEC 11 1940

1. PLACE OF DEATH: **St. Louis Mo.**
 (a) County _____
 (b) City or town _____
 (c) Name of hospital or institution: **City Sanitarium**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **20 days**
 In this community **About 8 years**
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 City or town **St. Louis**
 (If outside city or town limits, write "RURAL") **13**
 (d) Street No. **City Infirmary**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **Carrie Pride**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **No ne**

4. Sex **Female** 5. Color or race **Col.**
 6. (a) Single, widowed, married, divorced **Separated**

6. (b) Name of husband or wife **Otto Pride**
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Ab Oct. 5 1888**
 (Month) (Day) (Year)

8. AGE: Years **52** Months **7** Days **-**
 If less than one day _____ hr. _____ min.

9. Birthplace **Decatur Alabama**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **Green Wolfe**

13. Birthplace **Decatur Alabama**
 (City, town, or county) (State or foreign country)

14. Maiden name **Estia Stover**

15. Birthplace **Unknown Alabama**
 (City, town, or county) (State or foreign country)

16. (a) Informant **P. Reggendorf**

(b) Address **City Sanitarium**

17. (a) **Burial** (b) Date thereof **11/11/1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Wm. G. Bates**
 (b) Address **4107 Finney Avenue**

19. (a) **NOV 7 1940** (b) **J. F. [Signature]**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **11** day **2**
 year **1940** hour **4:15** minute _____ P. M.

21. I hereby certify that I attended the deceased from **10-14-40** to **11-2-40**, 19____;
 that I last saw her alive on **11-2-40**, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Generalized Arteriosclerosis (onset 1936x)

Due to **Chronic Myocarditis**
Myocardial degeneration

Due to **(onset 1936x)**

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **No**

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) _____ (e) Means of injury _____

23. Signature **Frank P. Smith** (M., D. or other) _____
 Address **5400 Arsenal** Date signed **11/15/40**

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

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

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

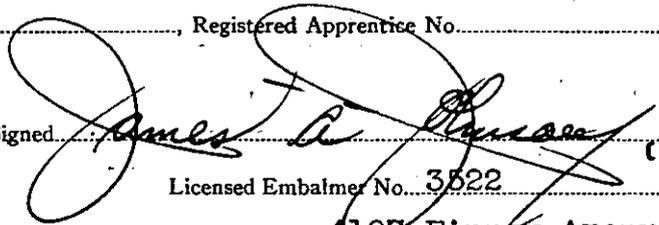
Not

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~X23~~ embalmed by me, or by.....

....., Registered Apprentice No.....

.....
working under my personal supervision.

Signed.....



Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

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, fact should be so stated above.