

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **10723**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis City Hospital #1 /  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 Days  
(Specify whether)  
 In this community Life  
years, months or days

3. (a) PRINT FULL NAME Robert Carrman

8. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased June 7, 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 5 22 hr. min.

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER  
 { 12. Name Jacob Carrman  
 { 13. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name Theresa Cockran  
 { 15. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Ann Morrison  
 (b) Address St. Louis City Hospital #1

17. (a) \_\_\_\_\_ (b) Date thereof 12-29-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Ritz

19. (a) **DEC 27 1940** (b) J. T. Brudeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis, 25.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 919 Market St.,  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 29,  
 year 1940 hour 8:45 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from November  
11, 1940 to November 29, 1940;  
 that I last saw him alive on November 29, 1940.

and that death occurred on the date and hour stated above.  
 Immediate cause of death wet Pyclocephritis  
± Possible Malignancy  
unknown as to stones

Due to \_\_\_\_\_  
 Due to 133A

Other conditions Secondary Anemia  
(Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations No operation  
 Of autopsy Anatomical Board  
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?  
(Specify type of place) (e) Means of injury

23. Signature J. McDonald (M. D. or other) \_\_\_\_\_  
 Address 1505 Lafayette Ave., Date signed 11/30/40

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 \_\_\_\_\_

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.**