No. 2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 8071

REC'D MAR 11 1941

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 274

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

**1. PLACE OF DEATH:**

(a) County: St. Louis

(b) City or town: Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County Hospital ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days (Specify whether years, months or days)

In this community 3 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Mo. (b) County: St. Louis 96

(c) City or town: Webster Groves 7
(If outside city or town limits, write "RURAL")

(d) Street No.: 924 Bell 4
(If rural, give location)

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

3. (a) PRINT FULL NAME: Emma Carter

3. (b) If veteran, name war: unknown

3. (c) Social Security No.: unknown

4. Sex: female

5. Color or race: colored

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

6. (b) Name of husband or wife: Bennie Carter

6. (c) Age of husband or wife if alive: 33 years

7. Birth date of deceased: Dec. (Month) 30 (Day) 1919 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 1 | 4 | hr. min. |

9. Birthplace: unknown (City, town, or county) / Tenn. (State or foreign country)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: Lucion Scott
13. Birthplace: unknown (City, town, or county) / Miss. (State or foreign country)

MOTHER
14. Maiden name: Annie Brown
15. Birthplace: unknown (City, town, or county) / La. (State or foreign country)

16. (a) Informant: Bennie Carter
(b) Address: 924 Bell ave

17. (a) (Burial, cremation, or removal) (b) Date thereof: 2 6 41 (Month) (Day) (Year)
(c) Place: burial or cremation: Father Dickson

18. (a) Signature of funeral director: J. C. Lewis
(b) Address: 27 Emmet Webster Groves

19. (a) FEB - 5 1941 (Date received local registrar) (b) R. Meyer MD (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 3 year 1941 hour 9 minute 50 a. M.

21. I hereby certify that I attended the deceased from 1-13-41, 19..., to 2-3-41, 19...; that I last saw her alive on 2-3-41, 19...; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Respiratory Failure | 12 hrs |
| Due to: Possible Toxemia of Pregnancy (Acute Yellow Atrophy) | 7 days |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |

Major findings:
Of operations:
Of autopsy:

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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: John R. Matthews (M. D. or other) ()
Address: St. Louis County Hosp. Date signed:

(Licensed Embalmer's Statement on Reverse Side)

125W

**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 J. Lewis

Licensed Embalmer No. 2077

P. O. Address Webster Groves Mo

**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, fact should be so stated above.**

No. 2
1-4-41
17-39
X26390

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# STANDARD CERTIFICATE OF DEATH

State File No. 8071

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 274

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

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**1. PLACE OF DEATH:**

(a) County St Louis

(b) City or town Clayton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (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 (b) County

(c) City or town (If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Emma Carteo

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race Col

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 21 Months 1 Days 4 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 3 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 , to 19 ; that I last saw h alive on 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure Duration

Due to Possible Toxemia of Pregnancy

Due to No delivery or abortion

Other conditions N M D. (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 144 P

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature John G Matthews (M. D. or other)

Address Co Hosp Date signed

SUPPLEMENTARY

(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 wi the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**