

Registration District No. _____ Primary Registration District No. _____

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:
Homer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Hrs. 32 Min.
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Bobbie Jean Carter

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased May 9 1943
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>NB</u>				<u>4 hr. 32 min.</u>

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Cleve Carter 13. Birthplace Marvel Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Johnnie Bee Jones 15. Birthplace Marvel Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Walter M. Sherrard, R.R.
(b) Address 2601 N. Whittier

17. (a) Burial (b) Date thereof MAY 27 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director H. Mischman
(b) Address 1614 1/2 N. Whittier

19. (a) MAY 26 1943 (b) J. F. Boudich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 4428 Garfield
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 10
year 43 hour 12 minute 50 a. M.

21. I hereby certify that I attended the deceased from 5-9-43
19 43 to 5-10 19 43
that I last saw h. er. alive on 5-10 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 E. Dickson no 0 (M. D. or other) _____
Address 2601 N. Whittier Date signed 5-24-43

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, fact should be so stated above.