

FILED MAR 1 1944

Registration District No. 318

Primary Registration District No. 1003

State File No. ....

Registrar's 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. PHILLIPPS HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 1/2 hours  
 (Specify whether  
 In this community L.I.F.A.  
 years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 17  
 (c) City or town ST. LOUIS 9 21  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3057 THOMAS  
 (If rural, give location)  
 (e) Citizen of foreign country? ..... (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME CLARENCE HENRY CARNES3. (b) If veteran, name war WORLD WAR I 3. (c) Social Security No. 489-10-55801

4. Sex MALE 5. Color or race COL. 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife LULAMAE CARNES 6. (c) Age of husband or wife if alive 34 years  
 7. Birth date of deceased 5 23 1890  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
53 8 22 hr. min.9. Birthplace ST. LOUIS MISSOURI  
 (City, town, or county) (State or foreign country)10. Usual occupation LABORER11. Industry or business LIGHT MYERS TOBACCO CO.

MOTHER FATHER  
 12. Name THOMAS CARNES  
 13. Birthplace MEMPHIS TENNESSEE  
 (City, town, or county) (State or foreign country)  
 14. Maiden name ANNIE Bibbs  
 15. Birthplace HENDERSON KENTUCKY  
 (City, town, or county) (State or foreign country)

16. (a) Informant Lula Mae Carnes(b) Address 3057 Thomas17. (a) BURIAL (b) Date thereof 23 19 44  
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation NATIONAL CEMETERY18. (a) Signature of funeral director John Riley(b) Address 3759 FINNEY AVENUE19. (a) FEB 17 1944 (b) J. F. Durack  
 (Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15  
 year 1944 hour 11 minute 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

Due to.....

Due to..... 930

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:

(c) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur? (City or town) (Country) (State).....

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work? (Specify type of place) (b) Means of injury ?23. Signature Thomas F. Callahan (M. D. or other).....Address Deputy Coroner Date signed 2-16-44

**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 Char. L. Howell

Licensed Embalmer No. 2452

P. O. Address 2834 Gamble

**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.**