

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 26 1944

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12630  
Registrar's No. 3633

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(c) Name of hospital or institution: St Marg's Inf. I  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
(Specify whether  
In this community 7 days  
years, months or days)

3. (a) PRINT FULL NAME Johnnie R. Carter

3. (b) If veteran, name war none 3. (c) Social Security No. 352-20-0397

4. Sex Female 5. Color or race 3 Colored 6. (a) Single, widowed, married, divorced 1 married  
6. (b) Name of husband or wife John F Carter 6. (c) Age of husband or wife if alive 28 years  
7. Birth date of deceased Jan 6 1919  
(Month) (Day) (Year)

8. AGE: Years 25 Months 3 Days 12 If less than one day hr. min.

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

10. Usual occupation Janitor

11. Industry or business U.S. Engineers Depot.

12. Name Wall Green

18. Birthplace Ark. I  
(City, town, or county) (State or foreign country)

14. Maiden name Alma West

15. Birthplace Newport Ark. I  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John F Carter

(b) Address Venue St

17. (a) Removal (b) Date thereof Apr 19 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East St Louis Ill

18. (a) Signature of funeral director H Marshall

(b) Address 2205 Mo Ave East St Louis Ill

19. (a) APR 10 1944 (b) J. H. Redick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County Madison  
(c) City or town Venue  
(If outside city or town limits, write "RURAL")  
(d) Street No. 315 Mercedes St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18  
year 1944 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from April 15  
1944 to April 18 1944

that I last saw him alive on April 18 and that death occurred on the date and hour stated above.

Immediate cause of death Palmar erythema

Due to Aggravated

Due to 1/2/12

Other conditions 1/2/12  
(Include pregnancy within 3 months of death)

Major findings: Of operations Aggravated

Of autopsy 1/2/12

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. F. Woodrow (M. D. or other) MD

Address 230 N. 2nd Date signed 4/18/44

**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 me  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Ben. H. Baldwin  
Licensed Embalmer No. 2420  
P. O. Address St. Louis, Ill.

**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.**