V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1944

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35732

Primary Registration District No. 1003

Registrar's No. 10299

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: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Week (Specify whether years, months or days)

In this community 14 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 4937 Forest Park
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME William Sanford Carpenter, M.D.

3. (b) If veteran, name war World War I

3. (c) Social Security No. No

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Lenore

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

7. Birth date of deceased Oct (Month) 26 (Day) 1871 (Year)

8. AGE: Years 73 Months 1 Days 6 If less than one day hr. min.

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

10. Usual occupation Doctor of Medicine

11. Industry or business

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

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

16. (a) Informant Helene Craig
(b) Address 532-20th NW - Washington

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-3-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Des Moines Iowa

18. (a) Signature of funeral director Harold A Rowland
(b) Address 4355 Washington

19. (a) DEC 4 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2nd year 1944 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from November 26, 1944 to December 2, 1944 that I last saw him alive on December 2, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac failure + portal v. inferior caval obstruction	x 4 days
Due to retro-peritoneal sarcoma (reticulum cell)	x 7 mos
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Large retro-peritoneal mass — 11-29-44

Of operations

Of autopsy Same

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 Herbert C. Megaard (M. D. or other) M.D.

Address Barnes Hospital, Date signed 12/2/44

(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 Howard B. Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis Mo

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.