

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 27 1944
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10567

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Missouri Baptist Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME HARRY L. CARTER.

3. (b) If veteran, name war None.

3. (c) Social Security No. 487-18-1643

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Katherine Carter.

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased July 15th 1889.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

55 ~~58~~ 4 25 hr. min.

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

10. Usual occupation Bookkeeper.

11. Industry or business Roman Art Co. Inc.

MOTHER FATHER { 12. Name Robert Carter.

13. Birthplace unknown | Virginia.
(City, town, or county) (State or foreign country)

14. Maiden name Dolly Lindsay.

15. Birthplace unknown | Virginia.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Katherine Carter.

(b) Address 6800 Wise Ave.

17. (c) Cremation (b) Date thereof 12/12/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory.

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) DEC 11 1944 (Date received local registrar)
J. F. Budek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(If outside city or town limits, write "RURAL")

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

(d) Street No. 6800 Wise Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10th
year 1944 hour 3:15 minute P. M.

21. I hereby certify that I attended the deceased from
Nov. 13, 1944 to Dec. 10, 1944;
that I last saw him alive on Dec. 10, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 3 weeks.

Due to 94.

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? _____

While at work? _____ (Specify type of place).
(e) Means of injury 0

23. Signature John Eversell (M. D. or other MD.)
Address 4129 Washington Blvd Date signed 12-11-44

Dr. N. J. Eversoff
4129 Washington Ave.
FR-4322

Hrs. { 11 am. to 12 noon
and
3 PM to 6 PM

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, Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address University City, 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.