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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

21753

FILED JUL 28 1945

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6319

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution 1/29/45 to 7/21/45 (Specify whether in this community years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 000 17

(c) City or town St. Louis Mo 619
(If outside city or town limits, write "RURAL")

(d) Street No. 4126 Westminister.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Matthew Carlton.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov 5th 1876 (Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 16 If less than one day hr. min.

9. Birthplace England. (City, town, or county) 4 (State or foreign country)

10. Usual occupation Unemployed.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ? (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name ?
15. Birthplace ? (City, town, or county) 9 (State or foreign country)

16. (a) Informant Stella Grady.
(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Edith E. Ambuster
(b) Address 4234 Manchester

19. (a) 7/22/45 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1945 hour 4 minute 55 AM.

21. I hereby certify that I attended the deceased from 1/29 1945, 19, to 7/21, 1945; that I last saw him alive on 7/21, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Decompensation	
Due to Chronic myocarditis	1943
Due to Generalized arteriosclerosis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

93d

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 0

23. Signature Palmer Romaine Bowdrick (M.D. or other)
Address 5600 - Arsenal Date signed 7-21-45

(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 John Kettler

Licensed Embalmer No. 3880

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.