

FILED JAN 31 1946

Primary Registration District No. 1003

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

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:  
6215 Eichelberger Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME John Bill Carter  
(b) If veteran, name war No. (c) Social Security No. 491-16-7180

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Divorced  
6. (b) Name of husband or wife Ruby Allen 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 2, 1907  
(Month) (Day) (Year)

8. AGE: Years 38 Months 2 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Clark County, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Used Automobile Dealer

11. Industry or business Self

MOTHER FATHER { 12. Name Charles Carter  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Rowena Edmonson  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Bobbie Long

(b) Address 6215 Eichelberger Ave.

17. (a) Burial (b) Date thereof 1/3/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. Concordia Lane

19. (a) JAN 2 (b) J. F. Bredesch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6215 Eichelberger Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 31  
year 1945 hour 10 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from April, 1944, to December 31, 1945; that I last saw him alive on December 31, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction

Due to Coronary heart disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: No operation  
Of operations \_\_\_\_\_

Of autopsy No, autopsy

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 Harford Phillips  
Address 1117 N. Union Date signed 12-1-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

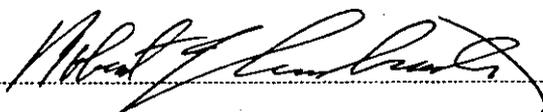
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**STATEMENT BY LICENSED EMBALMER**

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.....  


.....  
Licensed Embalmer No.....

P. O. Address.....

**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.**