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DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
JAN 21 1946
FILED 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 163
Registrar's No. 376

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: St. Louis City Hospital—Max C. Starkloff Memorial
(d) Length of stay: In hospital or institution
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County fdc
(c) City or town St. Louis 23 17
(d) Street No. 1828 So 10th St REAR. 9
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME LAURA CARR
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 4th
year 1946 hour 5:10 minute A M.
21. I hereby certify that I attended the deceased from 12/20/45
1/4/46
that I last saw her alive on 1/4/46
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife WILLIAM 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 10 25 77
(Month) (Day) (Year)

Immediate cause of death
Arteriosclerotic Heart Disease
Due to _____
Due to _____
Other conditions (Includes pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years 68 Months 2 Days 10 If less than one day hr. min.
9. Birthplace St. Louis, MO. (City, town, or county) (State or foreign country)
10. Usual occupation nil

MOTHER FATHER
11. Industry or business _____
12. Name JOHN MURPHY
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name ALICE GIBSON
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant MISS JOYCE
(b) Address 2331 MULLANPHY
17. (a) BURIAL (b) Date thereof JAN 17 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY
18. (a) Signature of funeral director Cullen Kelly
(b) Address 4386 Lindell
19. (a) JAN 13 1946 (b) J. J. Brudick
(Date received local registrar) (Registrar's signature)

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 Herbert C. Fritz 1/14/46 or other
Address _____ Date signed _____

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 James A. Lammers

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. FebRegistration District No. 318Primary Registration District No. 1003Registrar's No. 376

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:
 (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 Laura Carr

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Oct 25
(Month) (Day) (Year)8. AGE: Years 68 Months 7 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Nil

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of 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) (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

2372

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

JAN 31 1946

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