

S. No. 2
M-5-43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 169
Registrar's No. 738

FILED FEB 1 1946
Registration District No. 318

Primary Registration District No.

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:
Home G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME WOODIE CARTER
3. (b) If veteran, name war
3. (c) Social Security No. 491-16-4204

4. Sex Male 5. Color or race Cel
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec 10 1888
(Month) (Day) (Year)

8/ AGE: Years Months Days If less than one day
57 1 9 hr. min.

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

10. Usual occupation Labor

11. Industry or business

12. Name John Carter

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Grace Williams

(b) Address 3701 Vista Ave

17. (a) Burial (b) Date of death Jan 12 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis Public Cem

18. (a) Signature of funeral director John H. Humphreys

(b) Address 408 S. Illinois

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Bar
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 1317
(d) Street No. 5800 Arsenal (If rural, give location) ?
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19
year 1946 hour 1 minute 25 A. M.

21. I hereby certify that I attended the deceased from Jan. 12 1946 to Jan. 19 1946
that I last saw him alive on Jan. 19 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of Prostate with Metastasis to Pelvis, Ribs, Lungs (Terminal)
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Duration

Unk

51

Major findings:
Of operations
Of autopsy No

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
23. Signature O. L. Daniels (M. D. or other)
Address 2601 N Whittier Date signed 1/21/46

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 Chas. L. Howell

Licensed Embalmer No. 2457

P. O. Address 2874 Sample

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.