DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED SEP 16 1946

State File No. 31630

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 7747

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: PEOPLES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 DAYS (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County

(c) City or town ST. LOUIS 21
(If outside city or town limits, write "RURAL")

(d) Street No. 219a N. CHANNING
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME MARY CARTWRIGHT

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE 3

5. Color or race NEGRO

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

6. (b) Name of husband or wife SAM CARTWRIGHT

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased JAN (Month) 1 (Day) 1888 (Year)

8. AGE: Years 58 | Months 8 | Days 3 | If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name WILLIAM SCOTT
13. Birthplace MEMPHIS (City, town, or county) TENN (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace MEMPHIS (City, town, or county) TENN (State or foreign country)

16. (a) Informant's own signature Sam Cartwright
(b) Address 219a N. Channing

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-9-46 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director E. E. Pettis
(b) Address 3030 Bell Ave

19. (a) SEP 8 1946 (Date received local registrar) (b) J. J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 4 year 46 hour 12 10 minute 8 M.

21. I hereby certify that I attended the deceased from 8/14/46, 19__, to 9/4/46, 19__ that I last saw her alive on 9/4/46, 19__ and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral apoplexy	2 months
Due to: Hypertension	1 yr
Due to:	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address 3146 Euclide Date signed 9/5/46

(Licensed Embalmer's Statement on Reverse Side)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Esther R. Harris, Registered Apprentice No. 419 working under my personal supervision.

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Alden

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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

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THE STATE BOARD OF HEALTH OF MISSOURI

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Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7747

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:
(If not in hospital or institution, write street number or location)

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

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

3. (a) PRINT FULL NAME Mary Cartwright

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 Married

6. (b) Name of husband or wife Sam

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Jan 1 (Month) (Day) (Year)

8. AGE: Years 58 Months 8 Days Unless less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature) OCT 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

31630