

FILED AUG 12 1948

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis Mo**
(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: **#6-118 N. Bway**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St. Louis Mo**
(c) City or town **St. Louis Mo** (If outside city or town limits, write "RURAL")
(d) Street No. **#6-118 N. Bway** (If rural, give location)
(e) Citizen of foreign country? **23** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

HARRY CARTER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color **White** 6. (a) Single, widowed, married, divorced **unm**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **47-1881** years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE **67** Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **Wash was D.C.** (City, town, or county) _____ (State or foreign country)

10. Usual occupation **Wash was D.C.**

11. Industry or business **Wash was D.C.**

12. Name **Wash was D.C.**

13. Birthplace **Wash was D.C.** (City, town, or county) _____ (State or foreign country)

14. Maiden name **Wash was D.C.**

15. Birthplace **Wash was D.C.** (City, town, or county) _____ (State or foreign country)

16. (a) Informant **Thos. J. Blum**

(b) Address **1300 Park**

17. (a) **Anatomical Board** (b) Date thereof **JUL 31 1948** (Month) (Day) (Year)

(c) Place: burial or cremation **Anatomical Board**

18. (a) Signature of funeral director **Rowland Mortuary Service**

(b) Address **104 Manchester Ave.**

19. (a) **JUL 31 1948** (Date received local registrar) **J. T. Brudeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 20** month **July** day **20** year **1948** hour **10** minute **3** M.

21. I hereby certify that I attended the deceased from **am** _____, 19____, 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 **PERITONITIS Due to Ruptured Large Intestine**

Other conditions: **N.M.A.** (Includes pregnancy within 3 months of death)

Major findings: **1. 2. 3.** Of operations

Of autopsy **1. 2.**

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) _____ of means of injury **2**

23. Signature **[Signature]** (M. D. or other) _____

Address _____ Date signed **7/28/48**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE ALL LETTERS CAPITAL

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

Ralph W. Henson

Licensed Embalmer No. *13791*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1003

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6747

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)

3. (a) PRINT FULL NAME Harry Dahlen

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: 47 Years 6 Months 7 Days If less than one day, hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) AUG 14 1948 (b) [Signature]
(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 _____ Day _____ Year _____
 hour _____ minute _____ M.

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

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

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

Address _____ Date signed _____

SUPPLEMENTARY

5-24198