

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED JAN 29 1949

State File No. **3652**

No. 300
10-48

BIRTH NO. _____ REG. DIST. NO. **219** PRIMARY REG. DIST. NO. **4468** Registrar's No. **3**

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

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)		
a. COUNTY STE GENEVIEVE			a. STATE MO b. COUNTY STE GENEVIEVE		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. MARY'S		c. LENGTH OF STAY (in this place) LIFE	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. MARY'S		
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. MARY'S HI			d. STREET ADDRESS (If rural, give location) 9		

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) HELEN	b. (Middle) CHARA	c. (Last) CARTER	(Month) JAN	(Day) 22	(Year) 1949

5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH April 27 - 1923	9. AGE (In years last birthday) 25	10. UNDER 1 YEAR Months 5 Days 25	11. UNDER 24 HRS. Hours 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST MARY'S MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ELMER CARTER	13b. MOTHER'S MAIDEN NAME VIRGIE DICKENSON	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <i>Josephine Hamilton de. Bessy</i>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis Pulmonary		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		0524	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Marys Ste. Genevieve MO
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Dec 1, 1948, to JAN 22, 1949, that I last saw the deceased alive on JAN 18, 1949, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Arthur J. Beyceker M.D.</i>	23b. ADDRESS St. Genevieve MO	23c. DATE SIGNED 1-22-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1/24/49	24c. NAME OF CEMETERY OR CREMATORY ST MARY'S CATHOLIC	24d. LOCATION (City, town, or county) (State) ST MARY'S MO
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DATE REC'D BY LOCAL REG. January 25-49	REGISTRAR'S SIGNATURE <i>L. D. Karl - Jester</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. C. Basler de. St. Genevieve Mo</i>	ADDRESS
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RECEIVED

Officer No. 4

149-146

1-28-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Geo C. Bosh

Licensed Embalmer No. 1985

P. O. Address Ste. Genevieve 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.