

FILED JAN 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2354
Registrar's No. 179

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webster Groves</u>		<u>4927</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Bethesda General Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>1001 Big Bend Rd.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)	
<u>Carrie</u>						<u>Carson</u>	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
		<u>Jan.</u>		<u>6,</u>		<u>1950</u>	
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>white</u>		<u>widowed</u>		<u>2-7-1862</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>housewife, retired</u>						<u>Utica, New York</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U. S. A.</u>			
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE			
<u>August Seiler</u>		<u>Ursula Higess</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS			
				<u>Blauche Stiles Mc Rae Hoop</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
		i. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis + cerebral hemorrhage</u>					
		ANCECEDENT CAUSES					
		*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.					
		DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>					
		DUE TO (c) <u>Fracture upper end of femur</u>					
		ii. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY?
							YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
<u>HOME</u>		<u>Delaware Home</u>		<u>St. Louis</u>		<u>Mo. E9020</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>11-23-49</u>		<input type="checkbox"/>		<u>Fall from chair</u>			<u>21</u>
22. I hereby certify that I attended the deceased from <u>11-23-</u> 19 <u>49</u> , to <u>1-6-1950</u> 19 <u>50</u> , that I last saw the deceased alive on <u>1-6-</u> 19 <u>50</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)		23b. ADDRESS		23c. DATE SIGNED			
<u>H. H. Albrecht, M.D.</u>		<u>607 N. Grand Blvd.</u>		<u>1-6-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 9-1950</u>		<u>Ingersoll</u>		<u>Alton Ill</u>	
DATE REC'D BY LOCAL REGISTRY		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>JAN 8 1950</u>		<u>J. P. Rosaler</u>		<u>Fred McWilliam Washington</u>			

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

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.

Signed _____

William S. LaPorte

Signed _____
Student Embalmer

Licensed Embalmer No. *21699*

P. O. Address *St Charles 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.