

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 27 1951

State File No. 13888

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3732

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 45 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		6. STREET ADDRESS (If rural, give location) 4918 Wabada Ave.			

3. NAME OF DECEASED (Type or Print) a. (First) Sarah b. (Middle) Carter c. (Last) Carter			4. DATE OF DEATH (Month) (Day) (Year) 4 19 51		
5. SEX 3 Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, WIDOWED 2	8. DATE OF BIRTH Mar. 6, 1881	9. AGE (In years last birthday) 70	10. MONTH 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charleston, Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Will McLeod		13b. MOTHER'S MAIDEN NAME Maggie Smith		14. NAME OF HUSBAND OR WIFE John F. Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Beatrice Nesbitt 4918 Wabada Ave.	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive heart disease DUE TO (c) Diabetes  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			INTERVAL BETWEEN ONSET AND DEATH Unknown
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)	
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? 260X	

22. I hereby certify that I attended the deceased from 4-15-51, 19, to 4-19-51, 19, that I last saw the deceased alive on 4-19-51, 19, and that death occurred at 4:30 a.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Walter J. Thompson, M. D.</i>		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 4-20-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 23, 1951		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. Randle & Son 3133 Bell Ave.			
DATE REC'D BY LOCAL REG. APR 20 1951		REGISTRAR'S SIGNATURE <i>J. B. Pasater</i>			

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*J. J. Watson*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2698*

P. O. Address *2769 Charlotte*

**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.