

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11362

FILED APR 4 1953

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State File No. 1174

Registrar's No. 1174

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		State File No. 1174		Registrar's No. 1174					
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): St. Louis				c. LENGTH OF STAY (In this place): 30 yrs.		c. CITY (If outside corporate limits, write RURAL and give township): St. Louis 2119							
d. FULL NAME OF (If not in hospital or institution, give street address or location): HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				d. STREET ADDRESS (If rural, give location): 4476 West Belle									
3. NAME OF DECEASED (Type or Print) a. (First) Charles			b. (Middle) H.			c. (Last) Carter			4. DATE OF DEATH (Month) (Day) (Year) 1 - 29 - 1953				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married		8. DATE OF BIRTH Oct. 29 - 1875		9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months Days		IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Columbia, Tenn.				12. CITIZEN OF WHAT COUNTRY? USA.			
13a. FATHER'S NAME unknown				13b. MOTHER'S MAIDEN NAME unknown				14. NAME OF HUSBAND OR WIFE none					
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. 499-01-2868		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Paul Davis 4476 West Belle							
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>MEDICAL CERTIFICATION</i> <i>Tubercular Embolism</i>  ANTECEDENT CAUSES <i>causit: - Fr of right femur</i> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last:</i> <i>when he fell at 4476 West Belle about 1030 pm</i> DUE TO (b) <i>Jan 3 1953.</i>  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>								INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>ood Accident</i>								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT (Specify) <i>Accident</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <i>St Louis Mo.</i>									
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Jan 3 53 10<sup>30</sup> pm</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>E9040</i>									
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>7:55</i> m., from the causes and on the date stated above.													
23a. SIGNATURE (Degree or title) <i>Med Mrs. Hester</i>				23b. ADDRESS <i>1300 Clark</i>				23c. DATE SIGNED <i>1/30/53</i>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>2-2-1953</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Washington Park Cemetery</i>				24d. LOCATION: (City, town, or county) (State) <i>St. Louis County, Mo.</i>					
DATE REC'D BY LOCAL REG. <i>JAN 31 1953</i>		REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>W. J. Baker &amp; Son Funeral Home</i> <i>3201 N. Newstead Ave.</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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

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 comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.