

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40273

State File No.

FILED NOV 19 1953

318

PRIMARY REG. DIST. NO 1003

Registrar's No. 10352

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION People's Hosp.			d. STREET ADDRESS (If rural, give location) 1914 Biddle Street		
3. NAME OF DECEASED (Type or Print) Clara			a. (First) b. (Middle) c. (Last) Cartlidge		4. DATE OF DEATH (Month) (Day) (Year) 10 27 53
5. SEX Female	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 3, 1901	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Birmingham, Alabama /	
13a. FATHER'S NAME John Malry		13b. MOTHER'S MAIDEN NAME Amanda		14. NAME OF HUSBAND OR WIFE Romeo Cartlidge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Romeo Cartlidge 1914 Biddle	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>RENAL FAILURE</u> ANTECEDENT CAUSES DUE TO (b) <u>HYPERTENSIVE CARDIO-</u> DUE TO (c) <u>VASCULAR DISEASE</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>4 yrs.</u>
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? 443x	
22. I hereby certify that I attended the deceased from <u>Oct 13</u> , 19 <u>53</u> , to <u>Oct 27</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>53</u> , and that death occurred at <u>7:45</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Chas. P. Jones, M.D.</u>			23b. ADDRESS <u>2746 Franklin</u>		23c. DATE SIGNED <u>10-29-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>11-2-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Baranaka</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Baranaka Mo</u>
DATE REC'D BY LOCAL HEALTH DEPT. <u>OCT 31 1953</u>		REGISTRAR'S SIGNATURE <u>Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.C.B. Kausche, 12217 Grand</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..

Student.....
Signature of Student Embalmer

Signed *Guifon Swan*

Licensed Embalmer No. 4580

P. O. Address 1521 W. 4th

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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