

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6014**  
**1264**  
Registrar's No.

FILED MAR 4 1954  
BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>5 5253 Raymond Avenue., 2059</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) <b>CLAUDIA CARTER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>FEBRUARY 7, 1954</b>		
a. (First)		b. (Middle)		c. (Last)	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>5-25-1897</b>		9. AGE (In years less birthday) <b>56</b>		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Lesterville, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>William Johnson</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Bowers</b>	
14. NAME OF HUSBAND OR WIFE <b>Samuel Carter</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Nil</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Samuel Carter, 5253 Raymond Avenue.,</b>		17. ADDRESS		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>MEDICAL CERTIFICATION</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Adenocarcinoma of Rectum with</b>		INTERVAL BETWEEN ONSET AND DEATH		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Metastase.</b>	
DUE TO (c)		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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>154X</b>		22. I hereby certify that I attended the deceased from <b>7-15-53</b> , 19___, to <b>2-7-54</b> , 19___, that I last saw the deceased alive on <b>2-7-54</b> , 19___, and that death occurred at <b>12:45 a.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>John J. Leahy</b>		(Degree or title) <b>M.D.</b>		23b. ADDRESS <b>1515 Lafayette Avenue</b>	
23c. DATE SIGNED <b>2-8-54</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>2-8-54</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>City</b>		24d. LOCATION (City, town, or county) (State) <b>Ellington, Missouri</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe, 4700 Washington</b>	
DATE REC'D BY LOCAL REG. <b>FEB 9 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		ADDRESS	

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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.....

Licensed Embalmer No. 406

P. O. Address.....

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.