

FILED AUG 6 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24361

State File No.

Registrar's No. **6869**

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 Missouri b. COUNTY	
b. CITY OR TOWN Saint Louis		c. CITY OR TOWN Saint Louis	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3116 Chouteau		e. STREET ADDRESS (If rural, give location) 12 4541 Enright Avenue 2129	
3. NAME OF DECEASED (Type or Print) a. (First) Willie b. (Middle) c. (Last) Carvin		4. DATE OF DEATH (Month) (Day) (Year) 7 20 54	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 7-5-1914
9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HR. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (City and State or Foreign Country) Unknown	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE ---	

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 Mrs Bobbie Johnson St. Louis, Missouri	
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH Sudden
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rheumatic Heart Disease		
	DUE TO (c)		
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? YE <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? 47064

22. I hereby certify that I attended the deceased from **2-5**, 19**52**, to **7-20**, 19**54**, that I last saw the deceased alive on **7-8**, 19**54**, and that death occurred at **1:55** p.m., from the causes and on the date stated above.

Robert Kaplan MD 607 N. Grand **8-2-54**

23a. NAME OF CEMETERY OR CREMATORY Washington Park	23b. LOCATION (City, town, or county) (State) Saint Louis, Missouri
23c. DATE 7-23-54	23d. REGISTRAR'S SIGNATURE Earl Smith MD
23e. DATE REC'D BY LOCAL REG. JUL 24 1954	23f. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Spencer 1221 N Grand

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.....
Guyton Swan

Licensed Embalmer No. *4582*

P. O. Address *B21st St*

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.