

FILED OCT 26 1954

STANDARD CERTIFICATE OF DEATH

35217

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8954**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or town <b>St. Louis, Mo.</b> )		c. LENGTH OF STAY (In this place)	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>De Paul Hospital.</b>		STREET ADDRESS (If rural, give location) <b>5980a Ridge Ave. 20670</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Elizabeth</b>	b. (Middle)	c. (Last) <b>Carr</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 1, 1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>May 26, 1895</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Carr</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Sweeney</b>	14. NAME OF HUSBAND OR WIFE <b>None.</b>
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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>Marie Tighe</b>	ADDRESS <b>5233 Wabada Ave.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Glomerulo-Nephritis</b> 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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <b>592X</b>
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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?
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22. I hereby certify that I attended the deceased from **8/15, 1954**, to **10/1, 1954**, that I last saw the deceased alive on **10/1, 1954**, and that death occurred at **4:00 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert Potashnick, M.D.</b>	23b. ADDRESS <b>508 N. Grand Ave.</b>	23c. DATE SIGNED <b>10/2/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>10-5-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>OCT 2 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Harrigan &amp; Sheahan</b>	ADDRESS <b>4700 Washington.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 *John J. Haines*  
Licensed Embalmer No. *410*  
P. O. Address *St. Louis*

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.