

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3341

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) OR TOWN St Louis		c. CITY OR TOWN St 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 4609 Craight		e. STREET ADDRESS (If rural, give location) 12 4609 Craight 212 1/2	

3. NAME OF DECEASED (Type or Print)	a. (First) Bertha	b. (Middle)	c. (Last) Carter	4. DATE OF DEATH (Month) (Day) (Year)
				April 9, 1955

5. SEX F	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1891 Dec 25, 1891	9. AGE (In years less birthday) Months Days	# UNDER 1 YEAR	# UNDER 2 HRS.	# UNDER 5 MIN.
				50 last			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Lake Providence, La.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME John Chambers	13b. MOTHER'S MAIDEN NAME Norcia Thomas	14. NAME OF HUSBAND OR WIFE Henry Carter
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Lillian Harris	ADDRESS 4609 Craight
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) (Sclerosis)		
	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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201
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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 7:18 A.M., from the causes and on the date stated above.

23a. SIGNATURE Robert C. Taylor	(Degree or title) Coroner	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 4-14-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE April 15, 1955	24c. NAME OF CEMETERY OR CREMATORY Nathan Dixon	24d. LOCATION (City, town, or county) (State) Robertson, Missouri
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DATE REC'D BY LOCAL REG. APR 14 1955	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE E. B. Founce	ADDRESS 1221 N. Grand
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....
Geoffrey Swan

Licensed Embalmer No. 458

P. O. Address 1221²

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.