

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13190**  
Registrar's No. **3310**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY OR TOWN <b>St. Louis, Mo</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>12 4903<sup>1</sup> Fountain 212<sup>9</sup></b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3316 York Court</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Toreatha</b>	b. (Middle) <b>Bruce</b>	c. (Last) <b>Carter</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>4 9 55</b>
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5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>11-12-1914</b>	9. AGE (In years last birthday) <b>40</b>	IF UNDER 1 YEAR Days <b>4</b>	IF UNDER 1 YEAR Hours <b>21</b>	IF UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Govt.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Mississippi</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Geo. W. Bruce Sr.</b>	13b. MOTHER'S MAIDEN NAME <b>Emily Ballard</b>	14. NAME OF HUSBAND OR WIFE <b>Robt. Carter - Husband</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Robert Carter</b>	ADDRESS <b>4903<sup>1</sup> Fountain</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, asthma, 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>Cerebral Apoplexy</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>= Aneurysm</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 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)
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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? <b>334X</b>
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22. I hereby certify that I attended the deceased from **Feb. 28**, 19**55**, to **April 9**, 19**55**, that I last saw the deceased alive on **4/9**, 19**55**, and that death occurred at **11** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Walter A. Younger M.D.</b>	23b. ADDRESS <b>2337 Market</b>	23c. DATE SIGNED <b>4/13/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>4-15-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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DATE REC'D BY LOCAL REG. <b>APR 14 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. W. Bruce</b>	ADDRESS <b>4469 Washington</b>
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26. (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 .....  
Student Embalmer

Signed Leroy W. Fannister

Licensed Embalmer No. 4523

P. O. Address 3880 Easton

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