

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14544

FILED APR 26 1957

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

3353

Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
38 FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital #1		Length of stay in 1b 2 1/2	
d. STREET ADDRESS 2621 Pine St.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Carter		4. DATE OF DEATH Month Day Year 4 5 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) BlackJack, Mo.
13. FATHER'S NAME Fred. Foster		14. MOTHER'S MAIDEN NAME Ann ?	
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. none	17. INFORMANT Louise Shoby Address 1204 N. Leffingwell
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 4:39 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Patrick Taylor Coroner		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 4.8.57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-10-1957	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Russell Und. Co. ADDRESS 2732 Pine St		25. DATE RECD. BY LOCAL REG. APR 8 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. S.P.

**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 *James A. Cant* .....

Licensed Embalmer No. *468*

P. O. Address *J. Cant*

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.