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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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FILED SEP 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33076  
STATE FILE NUMBER  
Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 225

1. PLACE OF DEATH a. COUNTY <b>Saint Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Charles</b>		c. CITY OR TOWN <b>Saint Charles</b> e 92 3	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>1037 Olive</b>	
Length of stay in lb <b>DOA</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Elvira Carter</b>			4. DATE OF DEATH Month Day Year <b>Sept. 18 1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1885</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>8 24</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Luckett</b>		14. NAME OF HUSBAND OR WIFE <b>Charles Carter</b>	
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>None</b>		17. INFORMANT Address <b>Leslie Luckett, St. Charles, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>generalized arteriosclerosis 491 x</b>			

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.					

20d. INJURY OCCURRED WHILE AT WORK <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 <b>July 57</b> to <b>Sept 18, 57</b> and last saw her <b>him</b> alive on <b>Sept 17, 57</b> Death occurred at <b>1230 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <b>George K. Miller M.D.</b>		22b. ADDRESS <b>St. Charles Mo</b>		22c. DATE SIGNED <b>9-21-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 21, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>O'Fallon Cemetery</b>	
		23d. LOCATION (City, town, or county) (State) <b>O'Fallon, Mo.</b>			

24. FUNERAL DIRECTOR ADDRESS <b>W.C. Dallmeier &amp; Son, St. Charles</b>		25. DATE RECD. BY LOCAL REG. <b>Sept. 21-57</b>		26. REGISTRAR'S SIGNATURE	
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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 *Frank R. Amelung*

Licensed Embalmer No. *4832*  
P. O. Address *St. Charles*

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.