

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33324

318

1003

STATE FILE NUMBER

8274

Registration District No. Primary Registration District No. Registrar's No.

|  |                                  |   |  |  |  |   |  |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN St. Louis  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | c. CITY OR TOWN <i>St. Louis</i>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Homer G. Phillips</i>   |                                  |   | Length of stay in lb   | d. STREET ADDRESS <i>5075 Cabanne</i>  |  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><i>Jennie Carter</i>   |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><i>8 31 57</i>   |  |   |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>April 26, 1884</i>  |  | 9. AGE (In years last birthday)<br><i>73</i>                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><i>St. Louis MO</i>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><i>John Carter</i>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Mary Williams</i>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no. or unknown)<br><i>no</i>   |                                  | 16. SOCIAL SECURITY NO.<br><i>—</i>   |  | 17. INFORMANT Address<br><i>Walter Carter 5075 Cabanne</i>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i><br><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <i>Circulatory Disturbance</i><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>Hypertensive Cardiovascular Disease</i> |                                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>undet.</i>                         |  |
| 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<br>Hour Month, Day, Year<br>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 <i>8-28-57</i> to <i>8-31-57</i> and last saw her <i>alive</i> on <i>8-31-57</i><br>Death occurred at <i>2:30 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |   |  |  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><i>Maxim Roscan, M.D.</i>  |                                  |   |  | 22b. ADDRESS<br><i>2601 Whittier Street</i>  |  | 22c. DATE SIGNED<br><i>9-3-57</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 23b. DATE<br><i>9/5/57</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Washington Park</i>                                 |  | 23d. LOCATION (City, town, or county) (State)<br><i>St. Louis MO</i> |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><i>F. A. Green 4214 Delmar</i>   |                                  |   |  | 25. DATE RECD. BY LOCAL REG.<br><i>SEP 4 '57</i>   |  | 26. REGISTRAR'S SIGNATURE<br><i>Carl Smith MO</i>                         |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

(Licensed Embalmer's Statement on Reverse Side)

*mgs*

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..... *F. A. Green*

Licensed Embalmer No. *29*

P. O. Address *4214 Del...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.