

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43031

State File No. _____

FILED DEC 10 1957

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2980

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Koch. Mo</u>		c. CITY OR TOWN <u>ST LOUIS</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>2937 day</u>		e. STREET ADDRESS (If rural, give location) <u>2110 3114 LUCAS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ROBERT KOCH HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>S.</u> b. (Middle) <u>D.</u> c. (Last) <u>CARTER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 20 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MAR. 14. 1926</u>
9. AGE (In years last birthday) <u>31</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LADDER</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>MACON. MISSISSIPPI</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	

13a. FATHER'S NAME <u>GEORGE CARTER</u>	13b. MOTHER'S MAIDEN NAME <u>CORINNE SPANN</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>HOSPITAL RECORD KOCH HOSPITAL</u>	ADDRESS <u>KOCH HOSPITAL</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PULMONARY TUBERCULOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8+ years</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>002X</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>4-13-54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Pneumectomy Rt under Thoracostomy = TUBERCULOSIS</u>	20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" 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)
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

22. I hereby certify that I attended the deceased from Nov 4, 1949 to Nov 20, 1957, that I last saw the deceased alive on NOV 20 1957, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Frank Cohen</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Robert Koch Hosp. Koch Mo</u>	23c. DATE SIGNED <u>11-20-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>11/24/57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>OAKDALE CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO</u>
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DATE REC'D BY LOCAL REG. <u>11-22-57</u>	REGISTRAR'S SIGNATURE <u>Hubert P. Danaher</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Leo Jones</u>	ADDRESS <u>1343 Dr. Garrison Ave.</u>
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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.....
Signature of Student Embalmer

Signed *Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *3100 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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