

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020504

STATE FILE NUMBER

FILED JUN 9 1958

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 1438

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Ferdinand TWP</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>St. Ferdinand TWP</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1100 Northdale</b>		Length of stay in lb <b>15 yr</b>	d. STREET ADDRESS (If outside, give location) <b>1100 Northdale</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle Last <b>CARSON</b>			4. DATE OF DEATH Month <b>May</b> Day <b>26th</b> Year <b>1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 9 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13th, 1873</b>	9. AGE (In years (last birthday)) <b>84</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Aurora, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>A. Howerton</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Halfaker</b>		14. NAME OF HUSBAND OR WIFE <b>Frank Carson</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>306-12-4542</b>	17. INFORMANT Address <b>Frieda Sargent, 1100 Northdale</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>Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized Arteriosclerosis 4/200</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Thromboses of arteries, both arms.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days.</b>
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.) <b>—</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>July 1953</b> to <b>4-24-58</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>4-8-58</b> Death occurred at <b>3:25</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Norman G. Jones, M.D.</b> (Degree or title)		22b. ADDRESS <b>0 8321 N. Broadway (15)</b>		22c. DATE SIGNED <b>5-27-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>5/29/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Bethlehem Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>t. Louis Co., Mo.</b>		
24. FUNERAL DIRECTOR <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>		25. DATE RECD. BY LOCAL REG. <b>5/28/58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donker M.D.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Lawrence O. Gault*

Licensed Embalmer No. *4979*  
P. O. Address *St. Louis, Mo.*

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.