Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 58-034080

FILED SEP 22 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8720

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in Ib
27

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 914 N. 18th — Reside on Farm: Yes ☐ No ☐
2259

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Carter

4. DATE OF DEATH: Month 9 Day 5 Year 58

5. SEX: Male 2

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 31, 1902

9. AGE (In years last birthday): 55 — 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): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Building Corp.

11. BIRTHPLACE (City and state or country): Marshall, Texas

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: William Carter, Sr.

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Mrs. Lucenda Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 489-10-6393

17. INFORMANT: Mrs. Lucenda Carter — Address: 914 N. 18th. St.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Adenocarcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c): 153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Brain, Abcess

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ I

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 3-27-58, to 9-5-58 and last saw him alive on 9-5-58

Death occurred at 5:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Person or title): Herschell Hamilton, M.D.
Herschell Hamilton

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 9-8-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 9/11/58

23c. NAME OF CEMETERY OR CREMATORY: Father Dickson Cemetery

23d. LOCATION (City, town, or county) (State): Kirkwood, Missouri

24. FUNERAL DIRECTOR: G. Wade Granberry — ADDRESS: 4202 Finney Ave.

25. DATE RECD. BY LOCAL REG.: SEP 9 '58

26. REGISTRAR'S SIGNATURE: Carl Smith MD
M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Feiney

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.