

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041385

STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11478

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in lb Unk.	d. STREET ADDRESS (If outside, give location) 2119 4233 Cook
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Theodore Carr			4. DATE OF DEATH Month Day Year 11 27 58		
---	--	--	--	--	--

5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1911 47	9. AGE (In years at birthday) 47	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) Delivery Man	10b. KIND OF BUSINESS OR INDUSTRY Drug Store	11. BIRTHPLACE (City and state or country) Hutchinson, Kansas 1	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	---	--	--

13a. FATHER'S NAME Newton Carr	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE DeEtta Carr
-----------------------------------	--------------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W. War II	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. DeEtta Carr 4233 E. Cook Ave.
---	------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Hypertensive vascular disease</i>		
DUE TO (c) <i>331X</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypertensive Cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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 11-18-58 to 11-27-58 and last saw him alive on 11-27-58 Death occurred at 12:25 P m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>S. A. Inaer</i> , M.D.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 11-28-58
---	--------------------------------------	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/1/1958	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
--	------------------------	---	--

24. FUNERAL DIRECTOR F. Wade Granberry	ADDRESS 4202 Finney Ave.	25. DATE RECD. BY LOCAL REG. NOV 29 58	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith - M.D.</i>
---	-----------------------------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Guyton Swann*

Licensed Embalmer No. 4580.....

P. O. Address 4202 Finney Ave.

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.