

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019023

STATE FILE NUMBER

2 4917

FILED JUN 4 1959

Registration District No.

Primary Registration District No.

Registrar's No.

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4519 Elmbank	
3. NAME OF DECEASED (Type or print) First William Middle Albert Last Carter		4. DATE OF DEATH Month 5 Day 18 Year 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE (City and state or country) St. Paul, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Carter		13b. MOTHER'S MAIDEN NAME Bertha	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 492-03-9734		17. INFORMANT Edna Taylor Address 5704 St. Louis 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) Cardiac Insufficiency DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Mythrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 442x			INTERVAL BETWEEN ONSET AND DEATH undet.
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 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 5-9-59 to 5-18-59 and last saw xx him alive on 5-18-59 Death occurred at 7:35 P m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE J. G. Drax (Degree or title) , M.D.	
22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 5-20-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/22/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetary	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Wm. Smith ADDRESS 4019 Washington Blvd.		25. DATE RECD. BY LOCAL REG. MAY 20 '59	
26. REGISTRAR'S SIGNATURE Roal Smith, M.D.		27. REGISTRAR'S SIGNATURE mae	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

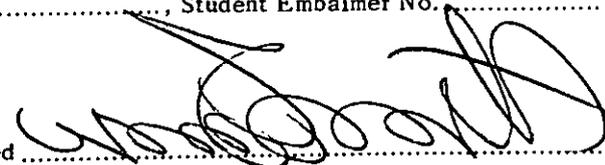
All diseases in Part I must be causally related.

300
1-57

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 

Licensed Embalmer No. 4371
P. O. Address St. Louis

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.