URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

EILED VS MAR 3 1960

60-009169
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 702

ENDED

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Length of stay in 1b YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7546 Byron Place — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ST LOUIS
c. CITY OR TOWN Clayton — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 7546 Byron Place — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Della Middle: Last: Carter
4. DATE OF DEATH Month Day Year: February 26, 1960
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 12/21/1885
9. AGE (last birthday): 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Okolona, Mississippi
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Richard Johnson
13b. MOTHER'S MAIDEN NAME: Charlotte Carter
14. NAME OF HUSBAND OR WIFE: William Carter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Eloise Miller — Address: 1545 Byron Place

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) Carcinoma, colon — INTERVAL BETWEEN ONSET AND DEATH: unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
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 Feb 1, 1960 to Feb 26, 1960 and last saw her/him alive on 2/23/60
Death occurred at C A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Lewis Littmann MD
22b. ADDRESS: 8231 Clayton Rd (17)
22c. DATE SIGNED: 2/29/60

23a. BURIAL, CREMATION, REMOVAL: Removal
23b. DATE: 3/1/60
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county) (State): Berkerely, Missouri

24. FUNERAL DIRECTOR: E B Koonce — ADDRESS: 1221 North Grand
25. DATE RECD. BY LOCAL REG.: 3-1-60
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed [illegible]

Licensed Embalmer No. [illegible]

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.