

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013474

FILED VS MAR 3 0 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 764

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKWOOD</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>KIRKWOOD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. JOSEPH'S HOSPR.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>413 WEST MADISON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>BERT RAY CARTER</u>	4. DATE OF DEATH Month Day Year <u>MARCH 4, 1960</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 3 1960</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>1</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>KIRKWOOD, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME <u>CATHERINE NAFFIGER.</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>413 WEST MADISON KIRKWOOD 22 MO</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poor maturity (delayed labor) Cervical dystonia</u>		INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from <u>3-3-60</u> to <u>3-4-60</u> and last saw her alive on <u>3-4-60</u> Death occurred at <u>3:17 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>John G. Longo Jr M.D.</u>	22b. ADDRESS <u>333 E. KIRKWOOD RD 22</u>	22c. DATE SIGNED <u>3-4-60</u>
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23a. BURIAL / CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAR. 7, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>M. J. Croghan</u> ADDRESS <u>831 E. Big Bend</u>	25. DATE RECD. BY LOCAL REG. <u>3-5-60</u>	REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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Webster Jones (Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.