

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013495

FILED VS APR 5 1960

317

Primary Registration District No. 548

Registrar's No. 855

STATE FILE NUMBER

| | | | | | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|------------------------------------|---|--|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY St Louis | | | | 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 WEBSTER GROVES | | Length of stay in 1b 1YR 4MO | | c. CITY OR TOWN ST. LOUIS. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BETHESDA DILLWORTH | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 6841 WALDEMAR | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) GUSTA CARR | | | | 4. DATE OF DEATH 3 - 10 - 60 | | | | | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 9-29-81 | | 9. AGE (last birthday) 78 | | 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) HOUSEWORK | | | | 10b. KIND OF BUSINESS OR INDUSTRY RETIRED | | 11. BIRTHPLACE (City and state or country) WINN MISSOURI | | 12. CITIZEN OF WHAT COUNTRY USA | | | | | |
| 13a. FATHER'S NAME LOUIS SCOTT | | | | 13b. MOTHER'S MAIDEN NAME VIRGINIA LEWIS | | | | 14. NAME OF HUSBAND OR WIFE WILLIAM THOS. CARR (DEAD) | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ZELMA ROBINSON 703 KIRKSHIRE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic vascular disease etc | | | | | | | | | | | | | |
| DUE TO (c) 420.1 | | | | | | | | | | | | | |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 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.) | | | | | | | | | |
| 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 | | | | | |
| 21. I attended the deceased from Mar. 7 1960 , to Mar. 10 1960 and last saw ^{her} him alive on Mar 10 1960 Death occurred at 2 15 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) O. Seabaugh M.D. | | | | | | 22b. ADDRESS Webster Groves Mo | | | 22c. DATE SIGNED 3/11/60 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE 3 | | 23c. NAME OF CEMETERY OR CREMATORY 60 U. P. CEMETERY | | 23d. LOCATION (City, town, or county) CUBA | | (State) MO | | | | | |
| 24. FUNERAL DIRECTOR Earl H. Leman OVERLAND MO | | | | 25. DATE RECD. BY LOCAL REG. 3-11-60 | | 26. REGISTRAR'S SIGNATURE J. C. Murphy M.D. | | | | | | | |

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 E. Sullivan

Licensed Embalmer No. 3501

P. O. Address Oreland.

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.