

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028193

FILED VS. AUG 12 1960

318

1003

7626

STATE FILE NUMBER

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) | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | | c. CITY OR TOWN St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2822 Cass | |
| 3. NAME OF DECEASED (Type or print) First George A. Middle _____ Last Carpenter | | 4. DATE OF DEATH | | Month 7 Day 29 Year 60 | |

| | | | | | | |
|---|-------------------------------|---|----------------------------------|--|--|--|
| 5. SEX Male | 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 9-1-1922 | 9. AGE (last birthday) 37 | IF UNDER 1 YEAR Months 10 Days 28 | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) Mississippi | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME George Carpenter | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Florence Carpenter | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT Address Mrs. Florence Carpenter 2822 Cass Avenue | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH Undet. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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) V Anginal Syndrome | | 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 |

| | | | |
|---|---|--|--------------------------|
| 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 **7-26-60** to **7-29-60** and last saw **him** alive on **7-29-60**
 Death occurred at **6:10 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | |
|---|------------------------------|---|--|------------------------------------|
| 22a. SIGNATURE (Name or title) <i>[Signature]</i> | | 22b. ADDRESS 2601 N. Whittier St. | | 22c. DATE SIGNED 7-30-60 |
| 23a. BURIAL, CREATION, REMOVAL (Specify) Removal | 23b. DATE 8-3-1960 | 23c. NAME OF CEMETERY OR CREMATORY Father Dickson | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri | |
| 24. FUNERAL DIRECTOR ADDRESS Ellis Funeral Home 2820 Stoddard St. | | 25. DATE RECD. BY LOCAL REG. AUG 3 1960 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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

Julian E. Calkins

Licensed Embalmer No. 4190

P. O. Address St. Paul

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.