

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033177

LED VS SEP 12 1960
 IDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1504 STATE FILE NUMBER

| | | | | | | | |
|--|---|---|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY St. Louis | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton | | a. STATE Missouri | | b. COUNTY St. Louis | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital | | Length of stay in lb D.O.A. | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. STREET ADDRESS 1925 North Market Street | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Character) (Carl) First (Earl) Middle V Last Carter | | | | 14. DATE OF DEATH Month August Day 22 Year 1960 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 7-14-1900 | 9. AGE (last birthday) 60 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Bodine Pattern & Fdy Co | | 11. BIRTHPLACE (City and state or country) Florida | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Joseph Carter | | | 13b. MOTHER'S MAIDEN NAME - - - - | | 14. NAME OF HUSBAND OR WIFE Dolores Carter | | |
| 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. 333-01-9130 | | 17. INFORMANT Address Mrs. Dolores Carter, 1925 N. Market Str | | | |
| 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 2 4 1/2 | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE | | | | | | YEARS | |
| 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 | | |
| 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 July 14, 1960 to 8/14/60 and last saw ^{XGX} him alive on 8/14/60 Death occurred at 2:11 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Robert A. Mayer MD | | | | 22b. ADDRESS 507 Nos 90 ST. LOUIS, 30 Mo | | 22c. DATE SIGNED 8/23/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 8-25-1960 | 23c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Missouri | | |
| 24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Av | | | | 25. DATE RECD. BY LOCAL REG. 8-23-60 | | 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 Glen W. Hay

Licensed Embalmer No. 3737

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.