

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027588

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2073

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

FILED AUG 11 1961 a. COUNTY St. Louis,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Breckenridge Hills		c. CITY OR TOWN Breckenridge Hills,	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3559 DeHart Pl.		d. STREET ADDRESS (If outside, give location) 3559 DeHart Pl.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First JAMES Middle G. Last CARTER		Month July Day 24th, Year 1961	
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 4-6-1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY Goodnor Const.Co.	11. BIRTHPLACE (City and state or country) New York, N.Y.
13a. FATHER'S NAME George Carter		13b. MOTHER'S MAIDEN NAME Mary Lynett	14. NAME OF HUSBAND OR WIFE Rita Carter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.War #2		17. INFORMANT Address Cy.Green- 9785 St Charles Rock Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown natural causes			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)			
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 checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 9:00 A. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Raymond Harsh</i> (Degree or title) Coroner Clayton, Mo.		22b. ADDRESS _____	
22c. DATE SIGNED 8/1/61		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal(Plane)	
23b. DATE 7-25-61		23c. NAME OF CEMETERY OR CREMATORY Valley Stream	
23d. LOCATION (City, town, or county) (State) Valley Stream, New York.		24. FUNERAL DIRECTOR ADDRESS Kriegshauser- 9450 Olive Blvd.	
25. DATE RECD. BY LOCAL REG. 7-24-61		26. REGISTRAR'S SIGNATURE <i>John C. Murphy Md.</i>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edwin A. Mc Dermott

Licensed Embalmer No. 3024

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.