

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031563  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 159 Primary Registration District No. 4249 Registrar's No. 24

FILED AUG 24 1962

VS 300  
Rev. 4/59

1 0500  
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4 1  
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9 4200  
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12 86.0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>HILLS BORO</u>		c. CITY OR TOWN <u>HILLSBORO</u>	
Length of stay in 1b <u>16 MO</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>CEDAR GROVE NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>CEDAR GROVE NURSING HOME</u>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>G.</u> Last <u>CARTER</u>		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>		11. BIRTHPLACE (City and state or country) <u>GOOD HOPE, OHIO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>JOSEPH GALLAWAY</u>		14. NAME OF HUSBAND OR WIFE <u>CLOYDER CARTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>NO</u>		17. INFORMANT <u>JOSEPH S. CARTER 4302 RANDALL PL.</u>	
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>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
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) <u>Diabetes Mellitus</u>			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 <u>Feb 28, 1961</u> to <u>July 7, 1962</u> and last saw her <sup>her</sup> alive on <u>July 1, 1961</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert C. Sanders MD</u> (Degree or title)		22b. ADDRESS <u>1507 Cass Ave.</u>	22c. DATE SIGNED <u>7-7-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>7-10-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATL. CEM. JEFF. BARRACKS, MO.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MO.</u>
24. FUNERAL DIRECTOR <u>SUEDMEYER &amp; SONS</u>		25. DATE RECD. BY LOCAL REG. <u>7/19/62</u>	26. REGISTRAR'S SIGNATURE <u>Carl E. Rice MD</u>

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS AUG 24 1962

**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 Robert M Murray

Licensed Embalmer No. 3749

P. O. Address St Louis Mo

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.