

SEP 25 1940

791

Primary Registration District No. **1003**

Registration District No.

1. PLACE OF DEATH: **2943. Easton Ave,**
(a) County _____
(b) City or town **St. Louis,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **XXX** **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **XXXX** (Specify whether years, months or days)
In this community **23 years,**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri.** (b) County _____
(c) City or town **St Louis,** **21**
(If outside city or town limits write "RURAL")
(d) Street No. **2943 Easton, Ave,**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **Born U.S.A.** years.

3. (a) PRINT FULL NAME **John L. Carr.** **600**
(b) If veteran, name war **XXXXXX**
3. (c) Social Security No. **498-18-7813**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **19th** year **1940.** hour **9:15** minute **0** M.

4. Sex **Male** 5. Color or race **col** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Mrs. Dove Carr.** 6. (c) Age of husband or wife if alive **63.** years
7. Birth date of deceased **June 4th 1876.**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 1940** 19 **to Aug 19th** 19 **40**
that I last saw him alive on **August 14th** 19 **40**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
64 **2** **15** hr. min.

Immediate cause of death **Malignancy of Prostate** Duration **1 year**

9. Birthplace **Columbia, Tenn.**
(City, town, or county) (State or foreign country)

Due to _____
Due to _____
Other conditions (Include pregnancy within 8-months of death)
Major findings:
Of operations _____
Of autopsy _____

10. Usual occupation **W.P.A. Project Lbr.**

11. Industry or business **W.P.A.**

MOTHER FATHER
12. Name **John Carr.**
13. Birthplace **Columbia, Tenn.**
(City, town, or county) (State or foreign country)
14. Maiden name **Dont Know.**
15. Birthplace **Dont Know.**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant **Dove Carr**
(b) Address **2943. Easton Ave; St Louis Mo**
17. (a) **Burial** (b) Date thereof **8-25-40.**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **R. C. Havelock**
(b) Address **2812, Thomas, St. St. Louis, Mo.**
19. (a) **AUG 21 1940** (b) **R. C. Havelock**
(Registrar's signature)

While at work? (Specify type of place) _____
(c) Means of injury _____
23. Signature **James B. Harris** (M. D. or other) _____
Address **2855 & Easton** Date signed **8-20-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

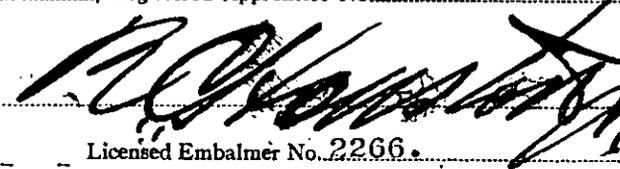
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Myself

Registered Apprentice No. XXX

working under my personal supervision.

Signed.....


Licensed Embalmer No. 2266.

P. O. Address 2312 Thomas, St,

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 this body is not embalmed, above space should be left blank.