

FILED SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

27365

F-4839

791

Registration District No.

1003

State File No.

Registrar's No.

7261

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 18 Days
(Specify whether _____)
 In this community 24 yrs.
years, months or days

3. (a) PRINT FULL NAME George Carr 1000

3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased October 23, 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	9	6	hr. _____ min.

9. Birthplace Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER { 12. Name J. C. Carr

13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Phoebe Ann Rirford

15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Ann Morrison
 (b) Address City Hospital, #1

17. (a) Burial (b) Date thereof 8-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. G. White

(b) Address City Hospital, #1

19. (a) AUG 28 1940 (b) J. F. [Signature]
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")
 (d) Street No. 3804 Delmar Blvd.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29,
 year 1940 hour 3 minute 24 P.M.

21. I hereby certify that I attended the deceased from July 11th,
 1940 to July 29, 1940;

that I last saw him alive on July 29, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease

Due to Chronic myocarditis

Due to Pulmonary Infarct.

Other conditions 930
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy as above.

Duration

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?

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature James T. [Signature] (M. D. or other) _____
 Address 1645 Lafayette Date signed 8/7/40

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, fact should be so stated above.