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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33781

NOV 16 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8478

1. PLACE OF DEATH:

(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:  
St. Luke's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether years, months or days)

In this community Life time  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John L. Carlisle

3. (b) If veteran, name war none 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Rilla B. Carlisle 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased February 18 1882  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>7</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace New Orleans La.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Chief Mech. Eng'r

11. Industry or business Board of Education

12. Name Frank C. Carlisle

13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Emily English

15. Birthplace Port Gibson Miss.  
(City, town, or county) (State or foreign country)

16. (a) Informant Betty Carlisle Lynch  
(b) Address 5363 Vernon Ave.

17. (a) Cremation (b) Date thereof 10/14/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Wagoner Und. Co.  
(b) Address 3621 Olive St. Louis, Mo.

19. (a) OCT 14 1940 (b) J. J. Brederick  
(Date received for registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis 5  
(If outside city or town limits, write "RURAL")

(d) Street No. 5363 Vernon Ave.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13 year 1940 hour 11:40 minute 0 M.

21. I hereby certify that I attended the deceased from Oct 1, 1940 to Oct 13, 1940 that I last saw him alive on Oct 13, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Caecum Mr.  
Carcinoma of liver Ms.

Due to Primary site Caecum

Other conditions Exploratory operation Oct 2 '1940  
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of Caecum  
Of operations Multiple metastasis in liver  
Of autopsy no

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) no

(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 T

23. Signature Chas E. Lyndman (M.D. or other) M.D.  
Address 3720 Washington Date signed Oct 13/40

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

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**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 the above constitutes grounds for revocation of license.)**

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