No. 2
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FILED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1003

State File No. 9093
2503

Registration District No. 791 Primary Registration District No. Registrar's No.

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

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town ST. LOUIS (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnard Free Skin & Cancer Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days. (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County STODDARD 103
(c) City or town Bernie (If outside city or town limits, write "RURAL") N.R.
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Charlotte Carson
3. (b) If veteran, name war No
3. (c) Social Security No. No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife John Carson
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased 12 (Month) 8 (Day) 1861 (Year)
8. AGE: Years 79 Months 3 Days 10 If less than one day hr. min.
9. Birthplace F (City, town, or county) Illinois (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business
FATHER 12. Name Hiram Loden
13. Birthplace ~~Illinois~~ (City, town, or county) Illinois (State or foreign country)
MOTHER 14. Maiden name Sarah Brown
15. Birthplace ~~Illinois~~ (City, town, or county) Illinois (State or foreign country)
16. (a) Informant ORA BETHUNE
(b) Address SIKESTON, Mo.
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 3-20-41 (Month) (Day) (Year)
(c) Place: burial or cremation MALDEN, Mo.
18. (a) Signature of funeral director Robert N. Hope
(b) Address 400 Washington Ave.
19. (a) MAR 19 1941 (Date received local registrar) (b) J. W. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19 year 1941 hour 8 minute 45 A.M.
21. I hereby certify that I attended the deceased from Feb 3, 1941, to March 19, 1941; that I last saw her alive on March 19, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Postoperative hemorrhage, internal jugular vein	
Due to: Carcinoma of rt. ear	8 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death): Arteriosclerotic ht. disease	

Major findings: Of operations: Carcinomatous involvement of mastoid process, ext. ear canal
Of autopsy:

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 William H. Gray (M. D. or other) M.D.
Address Barnard Skin & Cancer Hosp. Date signed 3/19/41

(Licensed Embalmer's Statement on Reverse Side)

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. Wilford G. Burnley

Licensed Embalmer No. 4202

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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