

S. No. 2
M-5-42
V. 5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29799**
Registrar's No. **8711**

FILED OCT 13 1943
318
Registration District No.

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....**St. Louis, Missouri**

(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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day, 8 hrs.**
4 mos. 7 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....**17**

(c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL") **11**

(d) Street No. **2506 Belleglade**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... **0**

3. (a) PRINT FULL NAME **Jean Carter**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **Col**

6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased **4 14 43**
(Month) (Day) (Year)

8. AGE: Years Months Days **5 29** If less than one day hr. **8** min.

9. Birthplace **Homer Phillips Hospital**
(City, town, or county) (State or foreign country)

10. Usual occupation **Child**

11. Industry or business **Child**

12. Name **Dereather Carter**

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

14. Maiden name **Dereather Dunning**

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

16. (a) Informant **Dereather**

(b) Address **2506 Belleglade**

17. (a) **Burial** (b) Date thereof **10-2-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington PK**

18. (a) Signature of funeral director **J. Thomas**

(b) Address **2734 Shricklan**

19. (a) **OCT 2 1943** (b) **J. J. Butler** Registrar's Signature
(Date received local registration) (Name)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **29,**
year **1943** hour **6** minute **30** P. M.

21. I hereby certify that I attended the deceased from **September**
28, 19 **43** to **September 29,** 19 **43**
that I last saw h **er** alive on **September 29,** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia - Primary** 3 days

Due to..... **107**

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

Major findings:
Of operations.....

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 **C. R. Merry** (M. D., **Missouri**)
Address **St. Louis** Date signed **10/1/43**

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 *Amelia Johnson*.....

Licensed Embalmer No. *35-22*.....

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.