

Registration District No. _____ Primary Registration District No. _____

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. John's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Thomas Lafayette Carter
 3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Nellie Carter 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased September 21 1878
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 2 28 hr. min.

9. Birthplace Mississippi County () Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Retired Farmer

MOTHER FATHER {
 11. Industry or business _____
 12. Name Elijah Carter
 13. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Dalton
 15. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
 16. (a) Informant Mrs. Nellie Carter
 (b) Address Anniston, Missouri
 17. (a) Burial (b) Date thereof 12-22-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Charleston, Mo.
Albert H. Hoppe
 18. (a) Signature of funeral director
 (b) Address 4700 Washington Blvd.
 19. (a) DEC 21 1944 (b) J. F. Budeck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 67
 (c) City or town Anniston 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) KR
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19
 year 1944 hour 12:40 minute P. M.

21. I hereby certify that I attended the deceased from Dec 6, 1944 to Dec 19, 1944
 that I last saw him alive on Dec 19, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death.	Duration
<u>Past operation shock</u>	<u>26 hrs.</u>
Due to <u>Cholelithiasis</u>	<u>4 years</u>
<u>Tuberculosis of spleen</u>	<u>"</u>
Due to <u>(no definite history of lung)</u> <u>Lungs not inspected</u>	
Other conditions. <u>2/1</u>	
(Include pregnancy within 3 months of death)	
Major findings: <u>Cholelithiasis + cholecystitis</u> <u>Tuberculosis of spleen & aden</u>	Underline the cause to which death should be charged statistically.
Of operations _____	
Of autopsy <u>none</u>	

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 W. Lindeman (M. D. or other) MD
 Address 4176 S. Sherr Ave Date signed 12/21/44

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

179

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.