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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4064

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1701

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)
In this community ~~Life~~ 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis, (If outside city or town limits, write "RURAL") 17 6
(d) Street No. 1526 Cole St. (If rural, give location) 125
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Lillian Carter

3. (b) If veteran, name war —

3. (c) Social Security No. None

4. Sex Female 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Jan. (Month) 14 (Day) 1898 (Year)

8. AGE: Years 47 Months 1 Days 5 If less than one day hr. min.

9. Birthplace Sparta Ill. (City, town, or county) State 1 (State or foreign country)

10. Usual occupation house work

11. Industry or business —

MOTHER FATHER

12. Name James Haynes

13. Birthplace Mississippi 1 (City, town, or county) (State or foreign country)

14. Maiden name Sallie McCarthy

15. Birthplace Mississippi 1 (City, town, or county) (State or foreign country)

16. (a) Informant Arthur Haynes

(b) Address 914 Chambers St.

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

(c) Place: burial ~~or cremation~~ St. Peters Cem.

18. (a) Signature of funeral director Manuel

(b) Address 4059 Finney Ave.

19. (a) FEB 21 1945 (Date received local registrar) J. F. Bredeek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19, year 1945 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from February 11, 1945 to February 19, 1945; that I last saw her alive on February 19, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Stricture of esophagus (prob. Malignancy.)	Unk.
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature W. C. Galloway (M. D. ~~or other~~)
Address 2601 Walton Date signed 3/20/45

(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 William C. McDowell, Registered Apprentice No._____, working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2/13

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.