S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7564

FILED APR 6 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2482

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: 3225 N. Florissant
Little Sister of The Poor
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 years (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. Little Sisters of The Poor
(If rural, give location)
3225 N. Florissant
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Daniel B. Carr

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 Widower

6. (b) Name of husband or wife Johanna E. Carr nee Fitzpatrick

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

7. Birth date of deceased February 18, 1865 (Month) (Day) (Year)

8. AGE: Years 80 Months 0 Days 29 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business Street car man

FATHER
12. Name James Carr
13. Birthplace Unknown (City, town, or county) Va. (State or foreign country)

MOTHER
14. Maiden name Margaret Doyle
15. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Daniel J. Carr
(b) Address 4403 N.20th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary. Cemetery

18. (a) Signature of funeral director Math. Hermann & Son
(b) Address 2161 East Fair, Ave.

19. (a) MAR 18 1945 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17 year 1945 hour 1 minute A M.

21. I hereby certify that I attended the deceased from January 4, 1945 to March 17, 1945 that I last saw him alive on March 14, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardio-vascular renal disease	2½ mo
Nephritis	2½ mo
Due to Chronic myocarditis	2?
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Omit any cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(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

23. Signature Bernard K Stoth (M. D. or other)
Address 2302 Salisbury St Date signed 3-17-45

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Gustav W. Dutile

Licensed Embalmer No. 4329

P. O. Address St. Louis Mo

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.

2B
3-45
I X43880

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STANDARD CERTIFICATE OF DEATH

State File No. 7564

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2482

SUPPLEMENTARY

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:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Daniel B. Carr

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 18 1869
(Month) (Day) (Year)

8. AGE: Years 80 Months 0 Days 0 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Mar Day 7
year 1945 hour minute M.

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

Immediate cause of death Ch. Myocarditis Cardio-vascular renal disease Chronic Nephritis

Due to Was more pronounced or ch. drowsy was more emphatic

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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)

(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

23. Signature Bernard H Stotts (M. D. ~~or other~~)

Address 2302 Salisbury St Date signed 6-2-45

7564