

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8922

1. PLACE OF DEATH:  
 (a) County St. Louis Mo  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution City Hosp #1  
 (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 Carrott Venus

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive abt. 1898

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE 48 Years Months Days If less than one day hr. min.

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

10. Usual occupation week

11. Industry or business week

12. Name week

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

14. Maiden name week

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

16. (a) Informant Thos. J. Gattanan  
 (b) Address 1300 GAR.

17. (a) Burial (b) Date thereof 10/18/46  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Albert H. Hoppe  
 (b) Address 4700 Washington Blvd.

19. (a) OCT 18 1946 (b) J. F. Breese  
 (Date received) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Wash.  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5816 DELMAR  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25 year 1946 hour 10 minute 20 AM.

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

Immediate cause of death: GASTRIC HEMORRHAGE FROM BLEEDING ULCER W. M. A.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 117  
 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)  
 (b) Means of injury \_\_\_\_\_

Signature Albert H. Hoppe (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 10/18/46

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

137

8928

NO EMBALM

---

---

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.**