

S. No. 2
OM-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

6093

FILED FEB 24 1947
318

State File No.

Registration District No. Primary Registration District No.

Registrar's No. 1497

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:
Mo. Baptist Hospital
(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 Missouri (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4415 Margaretta Ave.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... John Michel Carter

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

4. Sex male 0 5. Color or race White 6. (a) Single, widowed, married, divorced..... 0

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

7. Birth date of deceased..... 10 9 1946
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>4</u>	<u>3</u> hr. min.

9. Birthplace..... St. Louis Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name..... unknown 9

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

14. Maiden name..... Betty Carter

15. Birthplace..... Pine Bluff Arkansas /
(City, town, or county) (State or foreign country)

16. (a) Informant..... Mrs. Florence Hoover

(b) Address..... 4415 Margaretta Ave.

17. (a) burial (b) Date thereof..... 2/14/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Lake Charles Cemetery

18. (a) Signature of funeral director..... Drehmann-Harral

(b) Address..... 1905 Union Blvd.

19. (a) FEB 13 1947 (b) J. F. Brobeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 12
year 1947 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 7, 1947 to Feb. 12, 1947.
that I last saw him alive on Feb. 12, 1947.
and that death occurred on the date and hour stated above.

Immediate cause of death..... White enteritis

Due to.....

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... J. W. White (M. D. or other)

Address..... 4500 Olive Date signed..... 2/13/47

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

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..... *Warren A. Carter*

Licensed Embalmer No. *3534*

P. O. Address.....

No Embalming

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.