

No. 2
-12-45
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6094

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1584**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**

(c) Name of hospital or institution:
4061 Page Blvd.

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

(d) Length of stay: In hospital or institution **60 Yrs.** (Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME **Joseph C. Carter**

3. (b) If veteran, name war. **---**

3. (c) Social Security No. **404-28-5403**

4. Sex **Male** 2

5. Color or race **Negro**

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 **65** years

7. Birth date of deceased **September 20th 1875**

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	4	22	hr. _____ min.

9. Birthplace **Edwardsville Illinois**

(City, town, or county) (State or foreign country)

10. Usual occupation **Custodian**

11. Industry or business **---**

MOTHER FATHER

12. Name **Albert Carter**

13. Birthplace **Unavailable Illinois**

(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Curtaindell**

15. Birthplace **Boone Co. Missouri**

(City, town, or county) (State or foreign country)

16. (a) Informant **Nellie Carter**

(b) Address **4061 Page Blvd**

17. (a) **Burial** (b) Date thereof **2/17/47**

(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Charles J. Gates**

(b) Address **4107 Finney Ave.**

19. (a) **FEB 15 1947** (b) **J. F. Bredeck**

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **St. Louis**

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

(d) Street No. **4061 Page Blvd**

(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **12th**

year **1947** hour **5:30** minute **A.M.** M.

21. I hereby certify that I attended the deceased from **Feb. 7th** 19 **47** to **Feb. 12th** 19 **47**

that I last saw him alive on **Feb. 12th 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **4 Days**

Due to _____

Due to **Hypertension** Indef.

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? _____

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

23. Signature **J. Thomas** (M. D. or other) **M.D.**

Address **822 1/2 N. Jefferson** Date signed _____

STATEMENT BY LICENSED EMBALMER

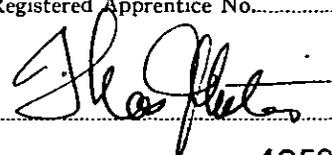
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates

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

working under my personal supervision.

Signed.....



Licensed Embalmer No. **4259**

P. O. Address **4107 Finney Ave.**

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.