

No. 2  
-1/47  
-17-39

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **18681**  
Registrar's No. **5031**

Registration District No. **318**

Primary Registration District No. **1003**

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

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: Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 10 days  
(Specify whether

In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County adao

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

(d) Street No. 2116 O'Fallon  
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME Blanche Mae Carter

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

3. (c) Social Security No. ....

4. Sex Female 5. Color or race Colored

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased 8/13/1917  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>30</u>	<u>9</u>	<u>4</u>	..... hr. / min.

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

10. Usual occupation House work

11. Industry or business Unknown

12. Name Garfield Johnson

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

14. Maiden name Cynthia Allen

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

16. (a) Informant Ernest Potts

(b) Address 2116 O'Fallon

17. (a) burial (b) Date thereof 5-20-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hughes Ark.

18. (a) Signature of funeral director David Brass

(b) Address 1405 Biddle St.

19. (a) MAY 23 1947 (b) J. J. Brueck  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17  
year 1947 hour 12 minute 55 P.

21. I hereby certify that I attended the deceased from 5-7, 19 47, to 5-17, 19 47  
that I last saw her alive on May 17, 19 47  
and that death occurred on the date and hour stated above.

Immediate cause of death Pyelonephritis - Acute  
non-calculous  
kidney complications  
preceded pregnancy  
in Uterus - Sub-involution  
Parturition - stillbirth

Other conditions (Include pregnancy within 3 months of death).....

Major findings of operations.....

Of autopsy: Yes

Duration Undet.

Underline the cause of 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 Clifford C. Sencock  
Address 2601 N Whittier Date signed 5/19/47

Jefferson City Printing Co.  
MAY 20 1947

(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

*Chas. L. Howell*

Licensed Embalmer No.

*2457*

P. O. Address

*7834 Gamble*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June 5087  
Registrar's No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 1003

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

3. (a) PRINT FULL NAME Blanche M. Carter  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race B  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Aug 13  
(Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 7 (If less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

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

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

19. (a) \_\_\_\_\_ (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-18681

Re. 1606