

No. 300  
M-10-47  
5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10039  
State File No. \_\_\_\_\_  
3205  
Registrar's No. \_\_\_\_\_

FILED APR 12 1948

318

Primary Registration District No. 1003

WRITE PLAINLY—USE 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:  
220 N. Kingshighway  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
70 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. 220 N. Kingshighway Blvd.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Carolyn G. Carpenter  
(b) If veteran, name war None  
(c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 2  
year 1948 hour one minute A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 1947 to April 2 1948  
that I last saw her alive on April 1 1948  
and that death occurred on the date and hour stated above.

4. Sex Female  
5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
(b) Name of husband or wife Geo. O. Carpenter Sr.  
(c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased December 29, 1858  
(Month) (Day) (Year)

Immediate cause of death  
Cerebral pneumonia  
followed cerebral arteriosclerosis  
thrombosis  
Due to cerebral arteriosclerosis  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
89 3 3 hr. \_\_\_\_\_ min.  
9. Birthplace Boston Mass.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

Physician  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name Andrew Greely  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Myrick  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs F. C. Bauchens  
(b) Address 5 Hortense Pl.  
17. (a) Cremation (b) Date thereof April 2, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Valhalla Crematory  
Wagoner Mortuary  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 4161 Lindell Blvd.  
19. (a) APR 2 1948 (b) J. F. Brown  
(Date received local registrar) (Registrar's signature)

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 Walter F. Fadel (M. D. or other) \_\_\_\_\_  
Address 3730 Washington Date signed 4-3-48

AUG 13 1948

---

---

**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.

*No Embalming*

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.**