

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

17454
State File No. 4605
Registrar's No.

FILED MAY 26 1948

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:
At Home 1817 Biddle St. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
15 Yrs. (Specify whether 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. **1817 Biddle St.**
21 (If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Gentry Carson.**
3. (b) If veteran, name war..... **No**
3. (c) Social Security No. **491-12-5965**
4. Sex **M** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **Single** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **July 4th, 1884**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **13th**
year **1948** hour **4:20** minute **7** M.
21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.
Duration

8. AGE: Years Months Days If less than one day
63 **4** **10** **9** hr. min.

Immediate cause of death.....
Chronic Hypertrophied Myocarditis
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

9. Birthplace..... **Mayfield Kentucky**
(City, town, or county) (State or foreign country)
10. Usual occupation..... **Labor**
11. Industry or business..... **Unknown**
12. Name..... **Cap Carson**
13. Birthplace..... **Ky.**
(City, town, or county) (State or foreign country)
14. Maiden name..... **Unknown**
15. Birthplace..... **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Minnie Mae Foex**
(b) Address..... **912 N. Whitter St.**
17. (a) **Burial** (b) Date thereof **5-18-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **Washington Park C**
18. (a) Signature of funeral director **Wesley Adams**
(b) Address..... **3849 Windsor Place**
19. (a) **MAY 18 1948** (b) **J. F. Braddock**
(Date received from 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?..... (Specify type of place)
While at work? (c) Means of injury.....
23. Signature **Patrick E. Taylor** (or other)
Address **Deputy Coroner** Date signed **5-18-48**

PHYSICIAN
Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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

F. A. Green

Licensed Embalmer No. *2963*

P. O. Address *14214 Dodman*

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.