

FILED OCT 23 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:  
ENROUTE TO CITY HOSPITAL 3  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community UNKNOWN  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAO

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 17

(d) Street No. 1522 SO. 3RD 9  
23 (If rural, give location) 0

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME IRA CARDEN

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12<sup>th</sup>  
year 1948 hour 7:45 minute \_\_\_\_\_ P. M.

4. Sex MALE 5. Color or race WHITE

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: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) 1876 (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

8. AGE: Years abt-72 Months - Days - If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min. 9

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

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

Immediate cause of death Chronic Myocarditis Aneurysm Duration \_\_\_\_\_

10. Usual occupation NEWS PAPER VENDOR

Due to \_\_\_\_\_

Due to Pl.

11. Industry or business UNKNOWN

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant WILLIAM BAKER

22. If death was due to external causes, fill in the following:

(b) Address 1506 (ROAD) SO. 7TH ST.

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) BURIAL (b) Date thereof OCT. 15-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation ST. MATTHEWS CEM.

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

18. (a) Signature of funeral director A.W. McLAUGHLIN

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(b) Address 2301 LAFAYETTE

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

19. (a) OCT 22 (b) J. B. Lester  
(Date received local health officer's report) (Registrar's signature)

23. Signature Patrol E Taylor, Sep Cal (M. D. or other) \_\_\_\_\_  
Address 1500 Clark Date signed 10-15-48

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**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..... *O. W. Cooper*.....  
Licensed Embalmer No. *3830*.....  
P. O. Address *9301 Lafayette*.....

**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.**