

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

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:
Lutheran Hospital
(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 NAME **ANNIE MAY CALVERT.**

3. (b) If veteran, name war **No**
3. (c) Social Security No. **No.**

4. Sex **Female** / 5. Color or race **White**
6. (e) 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 **March 9 1872**
(Month) (Day) (Year)

8. AGE: Years **76** Months **9** Days **14**
If less than one day _____ hr. _____ min.

9. Birthplace **St. Charles, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper.**

11. Industry or business _____

MOTHER FATHER {
12. Name **Edward Carter.**
13. Birthplace **Missouri**
14. Maiden name **Martha Lorraine.**
15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Lucy Young.**

(b) Address **6103 Washington Bly'd.**

17. (a) **Burial** (b) Date thereof **12/27/48.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cemetery**

18. (a) Signature of funeral director **C.R. Lupton & Sons.**

(b) Address **7233 Delmar Blvd.**

19. (a) **DEC 27 1948** (b) **J. B. Lassiter**
(Date received local registrar) (Registrar's signature)

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. **6103 Washington Ave.;**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **23**
year **1948** hour **5:15** minute _____ P. M.

21. I hereby certify that I attended the deceased from **12-10**, 19**48** to **12-23**, 19**48**
that I last saw **her** alive on **12-23**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary infarction, etc** Duration **1 1/2 h**

Due to **degenerative heart disease with auricular fibrillation** 2 wh

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

23. Signature **James M. Kraus** (M. D. or other) **MD**
Address **3901 Market St** Date signed **12-24-48**

Kraus

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

11170

Dr. J. M. Krause
3701 Grandeur Square
93 - 4430
10 to 1 P.M.

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 Clarence H. Murray

Licensed Embalmer No. 494

P. O. Address St. Louis, Mo

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.