

FILED MAR 4 1950

STANDARD CERTIFICATE OF DEATH

State File No. 6069

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1692

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place) 50 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 27 3150 Evans	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Clarence			b. (Middle) Carter		
c. (Last) Carter			5. SEX Male		
6. COLOR OR RACE Colored			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		
8. DATE OF BIRTH Feb. 13 - 1899			9. AGE (In years last birthday) 50		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk			10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (State or foreign country) Ala.			12. CITIZEN OF WHAT COUNTRY? U S A		

13a. FATHER'S NAME Manuel Carter		13b. MOTHER'S MAIDEN NAME Emma Harris		14. NAME OF HUSBAND OR WIFE Sarah Smith, Sister	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Undet.		16. SOCIAL SECURITY NO. Unk		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elizabeth Rhodes, 2601 N Whittier St	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease with		II. OTHER SIGNIFICANT CONDITIONS		Undet.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Antecedent Causes			
		DUE TO (b) Cerebral Hemorrhage			
		DUE TO (c) Undetermined			
		Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 443X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12-19, 19 49, to 2-11, 19 50, that I last saw the deceased alive on 2-11, 19 50, and that death occurred at 8:40p m., from the causes and on the date stated above.

23a. SIGNATURE James J. Herrick M.D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 2-17-50	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE FEB 21 1950		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State)		24e. NAME OF FUNERAL HOME		24f. ADDRESS	

DATE REC'D BY LOCAL REG. FEB 21 1950		REGISTRAR'S SIGNATURE J. B. Fasano		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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.