

FILED DEC 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 42987  
Registrar's No. 10375

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 42987		Registrar's No. 10375					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (In this place)			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119			d. STREET ADDRESS (If rural, give location) 1815 Saffin Ave				
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				3. NAME OF DECEASED a. (First) Carrie b. (Middle) Lovings c. (Last) Webster			4. DATE OF DEATH (Month) (Day) (Year) Dec. 4 1950						
5. SEX Female		6. COLOR OR RACE negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Oct 14, 1904		9. AGE (In years last birthday) 40		10. IF UNDER 1 YEAR: Months 0 Days 21		11. IF UNDER 100 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri			12. CITIZEN OF WHAT COUNTRY?				
13a. FATHER'S NAME Percy Loving				13b. MOTHER'S MAIDEN NAME Ida Bell			14. NAME OF HUSBAND OR WIFE John Webster						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH Undet.			
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis				ANTECEDENT CAUSES DUE TO (b) Undetermined DUE TO (c)									
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				II. OTHER SIGNIFICANT CONDITIONS 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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)						
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 332X											
22. I hereby certify that I attended the deceased from 12-2, 19 50, to 12-4, 19 50, that I last saw the deceased alive on 12-4, 19 50, and that death occurred at 12:30 a.m., from the causes and on the date stated above.													
23a. SIGNATURE D. J. Shampson M.D.				23b. ADDRESS 2601 N Whittier St				23c. DATE SIGNED 12-4-50					
24a. BURIAL, CREMA- TION, REMOVAL (Specify)		24b. DATE 12-7-50		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) St. Louis		24e. (State) Mo.					
DATE REC'D BY LOCAL DEC 6 1950		REGISTRAR'S SIGNATURE J. B. Lasater			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Atkins Road 3644 Family								

(Licensed Embalmer's Statement on Reverse Side)

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

0291

01117

.30 11

STATEMENT BY LICENSED EMBALMER

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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

X \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed Louis V. Atkins

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2842

P. O. Address 3644 Finley

(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.