

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37084**
Registrar's No. **9794**

FILED OCT 23 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 26 1820 N. 19th	

3. NAME OF DECEASED (Type or Print) William	a. (First)	b. (Middle)	c. (Last) Carter	4. DATE OF DEATH (Month) (Day) (Year) 9 30 53
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 1888	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ?	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ?	13b. MOTHER'S MAIDEN NAME ?	14. NAME OF HUSBAND OR WIFE ?
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME J. Masley medical Director's office	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis Far Advanced		
	II. OTHER SIGNIFICANT CONDITIONS Benign Prostatic Hypertrophy <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Surgical Absence Right Leg Below		

19a. DATE OF OPERATION 11-8-52	19b. MAJOR FINDINGS OF OPERATION Knee Carcinoma of Prostate	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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? 002X

22. I hereby certify that I attended the deceased from **9-20**, 19**52**, to **9-30**, 19**53**, that I last saw the deceased alive on **9-30**, 19**53**, and that death occurred at **2:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE E. B. Williams	(Degree or title) , M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 10-8-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) 10-31-53	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. OCT 14 1953	REGISTRAR'S SIGNATURE J. Carl Smith MO	BORNEAL ALLEN MORTUARY SERVICE 4104 Manchester Ave. St. Louis 10, Mo.	REGISTRAR'S SIGNATURE ADDRESS
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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, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.