

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **2649**
Registrar's No. **0626**

FILED FEB 2 1954

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 (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4315 Delmar	

3. NAME OF DECEASED (Type or Print) George		a. (First) _____ b. (Middle) W. c. (Last) Carter		4. DATE OF DEATH (Month) (Day) (Year) Jan. 19, 1954	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH October 7, 1887	
9. AGE (In years last birthday) 66		if UNDER 1 YEAR Months 3 Days 12		if UNDER 12 HRS. Hours _____ Mts. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (City and State or Foreign Country) Evansville, Indiana	
				12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME Abe L. Carter	13b. MOTHER'S MAIDEN NAME Bettie Johnson	14. NAME OF HUSBAND OR WIFE Lucille A. Carter
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 496-22-3718	17. INFORMANT'S SIGNATURE OR NAME Abel L. Carter	ADDRESS 512 E. Chestnut, Princeton, Ind.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION	
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Lung DUE TO (c) _____	
19. DATE OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 163X

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick E. Taylor Cooner	23b. ADDRESS 1300 Clark Avenue	23c. DATE SIGNED 1.20.54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1/22/54	24c. NAME OF CEMETERY OR CREMATORY Carmi, Illinois	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. JAN 20 1954	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates	ADDRESS 4107 Finney Ave.
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Arthur P. Heilliard

Licensed Embalmer No. 4021

P. O. Address 4107 Finney Avenue

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.