

FILED APR 28 1955

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

State File No. **13188**  
Registrar's No. **3253**

BIRTH NO. 17093-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

|  |                                  |  |  |  |  |
|--|----------------------------------|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY  |                                  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).<br>a. STATE<br>Missouri<br>b. COUNTY |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN<br>St. Louis  |                                  | c. LENGTH OF STAY (in this place)<br>5hrs 50   | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN<br>St. Louis                                    |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>Homer G. Phillips   |                                  |  | d. STREET ADDRESS (If rural, give location)<br>21 2221 Franklin  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print)<br>a. (First) Catherine<br>b. (Middle)<br>c. (Last) Carter   |                                  |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br>3 9 55   |  |  |
| <b>5. SEX</b><br>Fem. 3  | <b>6. COLOR OR RACE</b><br>Negro | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify)  | <b>8. DATE OF BIRTH</b><br>3-8-55  | <b>9. AGE</b> (In years last birthday) IF UNDER 1 YEAR Months Days<br>5 150          | <b>10. CITIZEN OF WHAT COUNTRY?</b><br>0   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)   |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br>Missouri                         | <b>12. CITIZEN OF WHAT COUNTRY?</b>  |
| <b>13a. FATHER'S NAME</b>  |                                  | <b>13b. MOTHER'S MAIDEN NAME</b><br>Catherine Carter   |  | <b>14. NAME OF HUSBAND OR WIFE</b>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | <b>16. SOCIAL SECURITY NO.</b>   | <b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS<br>Esther Sheward, Rt. 2601 N. Whittier   |  |  |
| <b>MEDICAL CERTIFICATION</b>   |                                  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b><br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |                                  | <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) Premature birth, neonatal death<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| <b>II. OTHER SIGNIFICANT CONDITIONS</b><br>Conditions contributing to the death but not related to the disease or condition causing death.   |                                  |  |  |  |  |
| <b>19a. DATE OF OPERATION</b>  |                                  | <b>19b. MAJOR FINDINGS OF OPERATION</b>  |  |  | <b>20. AUTOPSY?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)  |                                  | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  | <b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>   |  | <b>21f. HOW DID INJURY OCCUR?</b><br>7735  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)   |                                  | <b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. HOW DID INJURY OCCUR?   |  |
| <b>22. I hereby certify that I attended the deceased from 3-8-1955, to 3-9-1955, that I last saw the deceased alive on 3-9-1955, and that death occurred at 1:00 A.M., from the causes and on the date stated above.</b>             |                                  |  |  |  |  |
| <b>23a. SIGNATURE</b> (Degree or title)<br>William H. Linkler M.D.   |                                  |  | <b>23b. ADDRESS</b><br>2601 N. Whittier  |  | <b>23c. DATE SIGNED</b><br>3-30-55   |
| <b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify)   |                                  | <b>24b. DATE</b><br>4-30-55  | <b>24c. NAME OF CEMETERY OR CREMATORY</b><br>Anatomical Board  |  | <b>24d. LOCATION</b> (City, town, or county) (State)<br>St. Louis, Mo.                     |
| <b>DATE REC'D BY LOCAL REG.</b><br>APR 12 1955   |                                  | <b>REGISTRAR'S SIGNATURE</b><br>J. Carl Smith M.D.   |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS<br>Rowland Aker 4104 Manchester Ave. |  |

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**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.....

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.