

STANDARD CERTIFICATE OF DEATH

State File No. **23567**

FILED AUG 2 - 1955

BIRTH NO. **52573-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5515**

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

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 OR TOWN ST. LOUIS
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 79 3866 Washington	
3. NAME OF DECEASED (Type or Print) a. (First) CARTER b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) JUNE 24 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JUNE 24, 1955
9. AGE (In years last birthday) 7 Months 10 Days		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) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME BARNELL CARTER		13b. MOTHER'S MAIDEN NAME DOROTHY PATTERSON	14. NAME OF HUSBAND OR WIFE
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 HOSPITAL RECORD
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Immaturity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	INTERVAL BETWEEN ONSET AND DEATH
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)	21f. HOW DID INJURY OCCUR? 776X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from 6-24-55 , 19___, to 6-24-55 , 19___, that I last saw the deceased alive on 6-24-55 , 19___, and that death occurred at 7:40A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Mary A. Davis, M.D.		23b. ADDRESS 1515 Lafayette A-venue	23c. DATE SIGNED 6-25-55
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 6-25-55	24c. NAME OF CEMETERY OR CREMATORY Mounds, Ill.	24d. LOCATION (City, town, or county) (State) Mounds, Ill.
DATE REC'D BY LOCAL REG. JUN 25 1955	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Barrel Carter (Father) 3866 Washington	

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..

Not embalmed

Student.....
Signature of Student Embalmer

Signed *Beard Carter* (f)

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.