

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41901

FILED JAN 6 1956

State File No. 10906
Registrar's No.

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

1. PLACE OF DEATH a. COUNTY <u>St. Lou.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Masonic Home</u>		e. STREET ADDRESS (If rural, give location) <u>12 5351 DeLmar</u>	

3. NAME OF DECEASED a. (First) <u>William</u> b. (Middle) <u>Preston</u> c. (Last) <u>Carter</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 12 55</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Nov. 13, 1882</u>		9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR Days <u>1</u> IF UNDER 14 HRS. Hour Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ORDERLY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SANITARIUM</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Farmington, Mo.</u>	
13a. FATHER'S NAME <u>Francis M. Carter</u>		13b. MOTHER'S MAIDEN NAME <u>Maria McAnally</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel Roberts Carter, Dec'd.</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>497-05-1279A</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Robert A. Hall</u>	
				ADDRESS <u>3902 Lafayette St. Louis, Mo.</u>	

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.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CORONARY OCCLUSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		<u>5 YRS</u>	
		DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u>		<u>10 YRS</u>	
		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>HYPERTROPHIC OSTEARTHRTIS</u>		<u>10 YRS</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>42010</u>		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from APRIL 28, 1955, to DEC. 12, 1955, that I last saw the deceased alive on DEC. 12, 1955, and that death occurred at 9 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert A. Hall</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>3902 LAFAYETTE ST. LOUIS, MO.</u>	
23c. DATE SIGNED <u>DEC. 13, 1955</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>DEC. 13, 1955</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>MILLSTADT ILLINOIS</u>		24d. LOCATION (City, town, or county) (State) <u>ILLINOIS</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Stussman Millstadt Ill</u>	
DATE REC'D BY LOCAL REG. <u>DEC 13 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MO</u>		ADDRESS <u>Millstadt Ill</u>	

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.....
Frank Proff

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

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.