

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 26 1956

State File No. ....

318

1003

3452

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>3452</b>			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>ST. LOUIS, MISSOURI</b> )		c. LENGTH OF STAY (in this place) <b>2 Months</b>		c. CITY OR TOWN <b>St. Louis,</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>				e. STREET ADDRESS (If rural, give location) <b>15 2104 Gasconade 2159</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>WALDEAN</b>			b. (Middle)		c. (Last) <b>CARLTON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 3, 1956</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>July 3, 1929</b>		9. AGE (In years last birthday) <b>26</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13a. FATHER'S NAME <b>Earl Lovett</b>			13b. MOTHER'S MAIDEN NAME <b>Lovey Gamble</b>			14. NAME OF HUSBAND OR WIFE <b>James</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Lovey Lovett, 2104 Gasconade</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>GLIOMASTOMA MULTIFORME</b>					
				ANTECEDENT CAUSES					
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
II. OTHER SIGNIFICANT CONDITIONS				DUE TO (b) _____					
Conditions contributing to the death but not related to the disease or condition causing death.				DUE TO (c) _____					
19a. DATE OF OPERATION <b>2-4-56</b>		19b. MAJOR FINDINGS OF OPERATION <b>AS ABOVE</b>				193x		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) (Min.)		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 <b>3-1-</b> , <b>1956</b> , to <b>4-3</b> , <b>1956</b> , that I last saw the deceased alive on <b>4-3</b> , <b>1956</b> , and that death occurred at <b>4:15 Pm.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>H. Skrotz, MD</b> (Degree or title)				23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>			23c. DATE SIGNED <b>4-4-56.</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>4-6-1956</b>		24c. NAME OF CEMETERY OR <del>REPOSITORY</del> <b>New St. Marcus</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>APR 6 1956</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McLaughlin F.H., Inc. 2301 Lafayette</b>				

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

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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.....  
Signature of Student Embalmer

Signed..... *James R. Chapman* .....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.