

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28205

State File No. 7441  
Registrar's No.

FILED SEP - 6 1956

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 7441	
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. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 2/ 1414 N. 18th Street 22190			
3. NAME OF DECEASED (Type or Print) a. (First) James			b. (Middle)			c. (Last) Carter	
4. DATE OF DEATH (Month) (Day) (Year) 8 8 56		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH 11-17-1935		9. AGE (In years last birthday) 20		IF UNDER 1 YEAR Months 8		IF UNDER 2 HRS. Days 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Edmond Carter		13b. MOTHER'S MAIDEN NAME Queenie Dickson		14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT'S SIGNATURE OR NAME Mrs. Queenie Carter ADDRESS 1414 N. 18th St.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <i>Intra-abdominal Hemorrhage</i> <i>Contributory: Ruptured inferior vena-cava, Fractured dislocation of Atlas &amp; Axis.</i> DUE TO (b) <i>Following gunshot wounds and knife wounds inflicted on 11th &amp; Cole Sts. about 8:45 am, Aug 8, 1956.</i> DUE TO (c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death or condition causing death. 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		21a. ACCIDENT (Specify) <i>Homicide</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Street</i>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>St. Louis, Mo</i>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Aug 8, 56 12:45 pm</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>E983x</i>	
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 <i>2:30 A.M.</i> , from the causes and on the date stated above.							
23a. SIGNATURE <i>Joseph M. DePate, M.D.</i>				23b. ADDRESS <i>1300 Clark</i>		23c. DATE SIGNED <i>8/11/56</i>	
24. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>8-13-56</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis County, Missouri</i>	
DATE REC'D BY LOCAL REG. <i>AUG 11 1956</i>		REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Ellis Funeral Home, Inc. 2820 Stoddard St.</i>			

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.....

*James G. Carter*

Licensed Embalmer No. 46

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.