

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42881

FILED DEC 20 1956

318

1003

STATE FILE NUMBER

10557

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Clayton 44421	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS 8125 Roxborough (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Carrie Middle E. Last Craver		4. DATE OF DEATH Month Nov. Day 17, Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1893
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Scruggs-Vandervoort	
11. BIRTHPLACE (City and state or country) West Salem, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert Carver		14. MOTHER'S MAIDEN NAME Oleatha Kegley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Lorraine Leonhard, Springfield, Ill.		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct anterior			INTERVAL BETWEEN ONSET AND DEATH 11/12/56
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.1			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from Nov. 12, 1956 to Nov. 17, 1956 and last saw her alive on Nov. 17, 1956 Death occurred at 8:20 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE F.R. Bradley (Degree or title) M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 11/18/56
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-18-56	23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county) West Salem, Ill.		(State) _____	
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. NOV 19 1956	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Stanley H. Bishop

Licensed Embalmer No. 4

P. O. Address *St. Louis*

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.