

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003948

STATE FILE NUMBER

FILED FEB 4 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 207

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>_____</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MOLINE-ACRES</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS 220<sup>th</sup></b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HALLS-FERRY MEMORIAL-HOME</b>		Length of stay in 1b <b>4 1/2 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>FORMERLY: 1831-NO. 20<sup>th</sup> ST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>_____</b> Last <b>CARROW</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>20<sup>th</sup></b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 9<sup>th</sup> 1872</b>	9. AGE (In years last birthday) <b>86 YRS.</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MENDEL-COMPANY</b>	11. BIRTHPLACE (City and state or country) <b>FRENCH-VILLAGE-MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>UNKNOWN</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>ELIZABETH-CARROW (DECD)</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>490-01-5738</b>		17. INFORMANT Address <b>GRACE-TOAL = 4254 A. FARLIN-AV.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
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) <b>Old. left hemiplegia</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ 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 <b>Sept 15, 1954</b> to <b>Jan 20, 1959</b> and last saw him alive on <b>Jan 20, 1959</b> Death occurred at <b>2:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Lewis Littmann M.D.</b> (Degree or title)			22b. ADDRESS <b>8231 Clampton Rd (17)</b>		22c. DATE SIGNED <b>1/21/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JAN. 23<sup>RD</sup> 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FRIEDENS-CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS (COUNTY) MO.</b>
24. FUNERAL DIRECTOR <b>Brookland Und. Co.</b> ADDRESS <b>1827-HOGAN-ST.</b>		25. DATE RECD. BY LOCAL REG. <b>1-21-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>	

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 *J. W. Dunbar* .....

Licensed Embalmer No. *9653*  
P. O. Address *St. Louis, Mo. 12-124*

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.