

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 3 DAYS	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3215 ST. VINCENT

3. NAME OF DECEASED (Type or print) First JESSE Middle V. Last CARTER			4. DATE OF DEATH Month Oct. Day 14 Year 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1886	9. AGE (last birthday) 73	IF UNDER 14 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (City and state or country) ST. LOUIS MO	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JOHN CARTER		13b. MOTHER'S MAIDEN NAME JENNIE STUART		14. NAME OF HUSBAND OR WIFE LAURA CARTER	
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. NONE		17. INFORMANT CLARENCE CARTER, ARNOLD MO	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH WIC
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c) 491 x B

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. CONGESTIVE HF FAILURE - LUETIC HF DISEASE		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 a.m. p.m. Month, Day, Year	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 11 Oct. 1960 to 14 Oct. 1960 and last saw her/him alive on 14 Oct. 1960		Death occurred at 03:05 P m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) Nicholas L. Owen - M.D.		22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED OCT 17 1960
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-17-60	23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON	23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO	
24. FUNERAL DIRECTOR Bull-Campbell 5765 Delmar		25. DATE RECD. BY LOCAL REG. OCT 17 1960	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____

Signature of Student Embalmer

Signed

Elmer R. Calver

Licensed Embalmer No. 407

P. O. Address So Low

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