

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046163

FILED DEC 18 1961 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11453 STATE FILE NUMBER

AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 10 days	c. CITY OR TOWN Washington Park Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Little Rock Hospital, Inc.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 2210 N 49th St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Henry Middle Eugene Last Carter			4. DATE OF DEATH Month December Day 7 Year 1961
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 11-26-1896
9. AGE (last birthday) 65		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Smithland, Ky.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME William Henry Carter	
13b. MOTHER'S MAIDEN NAME Eva Leeper		14. NAME OF HUSBAND OR WIFE Anna Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna Carter E. St. Louis, 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 INFARCTION, ACUTE			INTERVAL BETWEEN ONSET AND DEATH 9 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 4201H			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CARCINOMA OF STOMACH			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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. 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 Nov. 28, 1961 to Dec. 7, 1961 and last saw ^{her} him alive on Dec. 7, 1961		Death occurred at 8:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>R. Greiner M.D.</i> (Degree or title)		22b. ADDRESS 1755 S. Grand Blvd.	22c. DATE SIGNED 12/8/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-10-1961	23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Gardens	23d. LOCATION (City, town, or county) (State) Belleville, Ill.
24. FUNERAL DIRECTOR Kassly Funeral Home, W. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. DEC 8 1961	26. REGISTRAR'S SIGNATURE <i>Loed Smith M.D.</i>

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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. R. [Signature]

Licensed Embalmer No. _____

P. O. Address _____

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.