

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-014098

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 823

FILED MAR 18 1963	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u> Length of stay in 1b <u>10 Years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>139 Reavis Place</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>139 Reavis Place</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First <u>Jennie</u> Middle <u>Edith</u> Last <u>Carter</u>	
4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1871</u>
9. AGE (last birthday) <u>92</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>
11. BIRTHPLACE (City and state or country) <u>New Brunswick, Canada</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Edward A. Hayes</u>	13b. MOTHER'S MAIDEN NAME <u>Smith</u>
14. NAME OF HUSBAND OR WIFE <u>Thomas W. Carter</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>
16. SOCIAL SECURITY NO. <u>6</u>	17. INFORMANT <u>John H. Carter</u> Address <u>139 Reavis Place</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> DUE TO (b) <u>Disease with Decompensation</u> yr Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 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	
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 checked="" 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 <u>5-22-56</u> to <u>3-6-63</u> and last saw her alive on <u>3-6-63</u> Death occurred at <u>12:45 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Ellsworth A. Westrup M.D.</u>	22b. ADDRESS <u>8540 Big Bend</u>
22c. DATE SIGNED <u>3-8-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>Mar. 9, 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co.</u> (State) _____
24. FUNERAL HOME <u>WALTER BERG - GERBER</u> ADDRESS <u>COLONIAL CHAPEL</u>	25. DATE REC'D. BY LOCAL REG. <u>3-8-63</u>
26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59
4007
240072
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4 1
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94200
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1290-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

WEBSTER GROVES 10, MO.

(Licensed Embalmer's Statement on Reverse Side)

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 Harry E. Monroe
Licensed Embalmer No. 4495

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.