

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

17145

1. PLACE OF DEATH

County.....
Township.....
City..... *St Louis* (No.....)

Registration District No. *782*
Primary Registration District No. *10005*

File No.
Registered No. *4665*
St. Ward

2. FULL NAME

William C. Carroll

(a) Residence. No. *3941 Page Bl* St., *9* Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 29 1894*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
29 1 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Police Officer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *St Louis*

10. NAME OF FATHER *James C. Carroll*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

12. MAIDEN NAME OF MOTHER *Ellen Sloan*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

14.

INFORMANT *James C. Carroll*
(Address) *3941 Page Bl*

15.

FILED *8 1923* *male* *Starkoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-7-23* 19

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... *10:30 a* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gun shot wound of head
1894 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Accident* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE

20. WAS THERE AN AUTOPSY? *Yes*
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Wm. D. ...* M. D.
578 19*23* (Address) *Dep. Coroner*

*State the DISEASE CAUSING DEATH, as in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

21. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

barway *5-9 1923*

22. UNDERTAKER ADDRESS
Arthur J. Donnelly *2039 Mark at*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

