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

Do not use this space.

21305

1. PLACE OF DEATH
County Jackson
Township Raw
City Kansas City No. 4046 Campbell St. Ward)
Registration District No.
Primary Registration District No.
File No.
Registered No. 2545

2. FULL NAME Evan M Carroll
(a) Residence. No. 4046 Campbell St., 15 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 16 - 1885

7. AGE Years 41 Months 9 Days 15 If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) K C Southern R R
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Michael Carroll
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Elizabeth Delaney
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) N.S.
(STATE OR COUNTRY)

14. INFORMANT Mrs F. M. Carroll
(Address) 4046 Campbell

15. FILED 7-2, 1927 M M Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 1 1927

17. I HEREBY CERTIFY, That I attended deceased from July 1 1927 to July 1 1927 that I last saw him alive on 7/1/27, and that death occurred, on the date stated above, at 4:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes
530
49
59
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Sarcoma of femur
(duration) 1 yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical X ray
(Signed) N O Kesson, M.D.
7/2, 1927 (Address) 909 Rialto

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt St Marys
DATE OF BURIAL 7/4 1927

20. UNDERTAKER J F O'Donnell Co
ADDRESS 3742 Main

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.