

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

Do not use this space.

38584

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis

(No. Jewish Hospital)

File No.

Registered No. 11266

St. (Ward)

2. FULL NAME

Sallie A Carlisle

(a) Residence. No. 4903 Washington St. 120 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

Female

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

John W Carlisle

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 22 1884

7. AGE

43 YEARS

MONTHS

5

DAY

24

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(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)

Illinois

10. NAME OF FATHER

Sam Webb

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

12. MAIDEN NAME OF MOTHER

Julia Webb

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

14.

INFORMANT (Address)

John W Carlisle
4903 Washington

15.

FILED

17 1927 Mar 6 Starkoff

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 19 27

17.

I HEREBY CERTIFY, That I attended deceased from Dec 5, 1927, to Dec 16, 1927, that I last saw h. alive on Dec 16, 1927, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gangrene of subclavian
Artery of left hand
1274 (duration) 2 yrs. 6 mos. 2 ds.

CONTRIBUTORY (SECONDARY)

prophylactic shock
(duration) 2 yrs. 2 mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Dec 9 1927

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS operation & autopsy

(Signed) J. Starkoff

12/16, 1927 (Address) Jewish Hospital

*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

DATE OF BURIAL

Valhalla Cemetery Dec 16 19 27

20. UNDERTAKER

ADDRESS

Drehmann Harold 1925 Union

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

