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

Do not use this space.

130555

File No. .....

Registered No. 1306

1. PLACE OF DEATH

County: Jackson

Township: Raw

City: K.C. Mo. (No. K.C. General Hospital St. ..... Ward)

Registration District No. .....

Primary Registration District No. .....

2. FULL NAME: Margaret Weaver Carroll

(a) Residence. No. 2844 College Av. St., 11 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: Fe

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Divorced

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Wm Daniel Carroll

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 22-1904

7. AGE: Years 24 | Months 2 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

(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): K.C. Mo.

PARENTS

10. NAME OF FATHER: Jno. C. Longacre

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Texas

12. MAIDEN NAME OF MOTHER: Emma Meek

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Texas

14. INFORMANT: John C. Longacre
(Address) 808 Brooklyn Av.

15. FILED: 9/5, 1928 M M Crockett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept. 14, 1928

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 ..... m.

Deputy Coroner

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lacerated Perineum

Menses a Woman

ICD 166

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... 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? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Earl Goldsmith, M.D.

9/14, 1928 (Address) Deputy Coroner

*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. Washington | DATE OF BURIAL: Sept. 15, 1928

20. UNDERTAKER: Mrs. C. L. Forster | ADDRESS: K.C. Mo.

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.

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