

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

Do not use this space.

42265

1. PLACE OF DEATH

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

Registration District No. *791*
Primary Registration District No. *1008*

File No.
Registered No. *11984*
St. *24th* Ward)

2. FULL NAME

Shirley Carson
(a) Residence. No. *3947 1/2 Cottage 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 *1* yrs. *8* mos. *10* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Single</i>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Mar. 28, 1928</i>				
7. AGE	YEARS <i>1</i>	MONTHS <i>8</i>	DAY <i>10</i>	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *nil*
(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 Mo.

10. NAME OF FATHER

Chester L. Carson

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

St. Louis Mo.

12. MAIDEN NAME OF MOTHER

Marie Winter

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

St. Louis Mo.

14.

INFORMANT..... *Lorraine Krower*
(Address) *ISOLATION HOSPITAL*

15.

FILED..... *DEC 9 1929* *W. C. Starkey*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-8 1929*
17. I HEREBY CERTIFY, That I attended deceased from *12-7* 19*29*, to *12-8* 19*29*, that I last saw her alive on *12-8*, 19*29*, and that death occurred, on the date stated above, at *7:00 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis, Meningococci Epidemic
18

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY)

24

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)..... *W. C. Starkey*, M. D.

12-9 1929 (Address) *ISOLATION 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

Calvary

Dec 10 1929

20. UNDERTAKER

ADDRESS

W. C. Starkey *728 Grand*

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

