

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

Do not use this space.

6372

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **St. Johna Hoop**)

File No.....

Registered No. **1141**

St. Ward)

2. FULL NAME *Mary Helen Carroll*

(a) Residence. No. **1327 Lewis Ave. St.** **12** Ward.

St. Louis Co. Mo.
(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 *Marten J. Carroll.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 12 1862*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 9 19

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

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Missouri*
(STATE OR COUNTRY)

10. NAME OF FATHER *John Haley*

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

12. MAIDEN NAME OF MOTHER *Budget O'Brien*

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

14. INFORMANT *Mr. Martin J. Carroll*
(Address) *1527 Lewis Ave.*

15. FILED *1933* *Mar E. Parkley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 19 1930*

17. I HEREBY CERTIFY That I attended deceased from *Jan 27th*, 19*30*, to *Feb 1st*, 19*30*. that I last saw h. ed. alive on *Feb 1st*, 19*30*, and that death occurred, on the date stated above, at *4:45* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
162

CONTRIBUTORY (SECONDARY) *Similarity* (duration) *About 3 days* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *at home* (duration) yrs. mos. ds.

IF NOT AT PLACE OF DEATH. *1527 Lewis*

0 DID AN OPERATION PRECEDE DEATH? *No.* DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS *Clinical*
(Signed) *Raymond D. Barnea, M. D.*
. 19 (Address) *515-20 Wall Bldg*

*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 *Calvary Cemetery* DATE OF BURIAL *1-4 1930*

20. UNDERTAKER *Geo. L. Cleitsch* ADDRESS *5966 Eastern Ave.*

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.

WHILE PERFECT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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3903 Olive St.

1 to 3 75

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1409 Bell Tel.