

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

Do not use this space.

16082

1. PLACE OF DEATH

County Kansas Jackson
Township Kan
City Kansas City Mo (No. 1007)

Registration District No. 399
Primary Registration District No. 1007

File No. 1
Registered No. 1990
St. _____ Ward _____

2. FULL NAME

Irene Harvey Carrel

(a) Residence. No. 1305 Summit St., 1 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 23, 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
6 3 15

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) None
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Chicago, Ill.
(STATE OR COUNTRY)

10. NAME OF FATHER Steve Carrel

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

12. MAIDEN NAME OF MOTHER Sybil Bassett

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

14. INFORMANT Steve Carrel
(Address) 1305 Summit

15. FILED 5/9, 1930 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 1930

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930 to May 8, 1930. That I last saw him alive on May 8, 1930, and that death occurred, on the date stated above, at 11:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute appendicitis & perforation
121A
129 (duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) Peritonitis
(duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF BIRTH _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF May 6, 1930

19. WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? lab. clinical
(Signed) A. Pakula, M.D. M. D.
5/9, 1930 (Address) Mercy 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 Wall Hill DATE OF BURIAL 7/10 1930

20. UNDERTAKER Wall Hill ADDRESS _____

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.

WHITE PRINT, WITH UNWADING INK—THIS IS A PERMANENT RECORD

mercy

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