

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

Do not use this space.

7675

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 2003

City St. Louis (No. City Hospital)

File No.

Registered No. 2036

St. Ward)

2. FULL NAME

(a) Residence. No. 11204 St. 25 Ward.

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

(CATRON)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 4 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
72 3 9

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sawyer, 2nd
(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) Iowa

10. NAME OF FATHER Simon Carroll

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) City Hospital

15. FILED FEB 16 1931 Ray C. Carter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 13 1931

17. I HEREBY CERTIFY That I attended deceased from Jan 27 1931 to Feb 13 1931 that I last saw him alive on Feb 13 1931 and that death occurred, on the date stated above, at 8:35 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

936
950 Chr. Myocarditis

(duration) yrs. mos. ds.
CONTRIBUTORY Cardiac decompensation (SECONDARY)

18. WHERE DISEASE CONTACTED (IF NOT IN PLACE OF DEATH) City Hospital

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Jerome Thomson M. D.

7/13 1931 (Address) City 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 New St. Marcus DATE OF BURIAL 2-16 1931

20. UNDERTAKER Wm. Schumacher ADDRESS 3013 Mcranee

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

Carroll