

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.

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

Do not use this space.

MAY 27 1936

18049

1. PLACE OF DEATH

County St. Louis Registration District No. 1123  
Township Carondelet Primary Registration District No. 6248 E  
City (No. Mk. St. Rose Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 137

2. FULL NAME Grace Carey

(a) Residence, No. 2013 N. 20th St. St. \_\_\_\_\_ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX F. 4. COLOR OR RACE Sk. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) uf

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/14, 1936

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

22. I HEREBY CERTIFY, That I attended deceased from May 13, 1935 to 4/14, 1936  
I last saw her alive on 4/14, 1936. Death is said to have occurred on the date stated above, at 4:45 p. m.  
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
38 — — —

Surgical Shock 4/2/36  
Following Thoracoplastic Operation 1/36

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Other contributory causes of importance:  
Pulmonary tuberculosis 1931

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

Name of operation Thoracoplasty Date of 4/2/36  
What test confirmed diagnosis? Sk. Was there an autopsy? Yes

13. NAME Michael Carroll

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

23. If death was due to external cause (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

15. MAIDEN NAME Agnes Gallard

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

17. INFORMANT (ADDRESS) Michael T. Carroll  
2411 Clara Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE Apr. 7, 1936

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

19. UNDERTAKER (ADDRESS) Goodpastor & Goodpastor  
2328 N. Louis Ave

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) John J. Deime, M. D.  
(Address) 9101 So. Blvd.

20. FILED April 5, 1936 J. Mowrey Registrar.

