

FEB 16 1938

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

4121
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 96
 (b) Township Dorsey Primary Registration District No. _____ Registered No. 26
 (c) City University City (d) Street No. 6334 McPherson Ave St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Pauline S. Carroll, 640

(a) Residence, No. 6334 McPherson Ave. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 4, 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm. H. Carroll

22. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1937, to Jan. 4, 1938

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 2, 1877

I last saw him alive on Jan 4, 1938. Death is said to have occurred on the date stated above, at 2:30 p.m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 60 1 2

The principal cause of death and related causes of importance were as follows:

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

Mitral insufficiency
Myocarditis, chronic
Date of onset 1934
1936

12. BIRTHPLACE (CITY OR TOWN) Berlin
(STATE OR COUNTRY) Germany

Other contributory causes of importance:
Anemia, secondary 1937
Nephritis, chronic, 1937

FATHER 13. NAME Schultz

14. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Boye

16. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY)

Name of operation None Date of _____
 What test confirmed diagnosis? Varicella Was there an autopsy? No

17. INFORMANT Mrs. Winifred Mac Rae
(ADDRESS) 462 Pasadena, Webster Groves

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? None Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL CREATION OF RECORD
PLACE Bellefontaine DATE Jan. 5, 1938

Manner of injury None
 Nature of injury _____

19. FUNERAL DIRECTOR Wagoner Undertaking Co
(ADDRESS) 3621 Olive St.

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Paul A. Ferguson, M. D.

20. FILED 1-5 THEODORE D. McNEEL, D. D. P. H.
Deputy State Registrar Local Registrar

(Address) Glennwood Sanatorium
Webster Groves, Mo.

Cause of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

96
16
5

STATEMENT BY LICENSED EMBALMER

I, Elmer C Grothe Licensed Embalmer No. 3351

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed Elmer C Grothe.....

Licensed Embalmer No. 3351

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)