REC'D AUG 1 1939

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

25098
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan
(b) Township or City St. Joseph
Registration District No. 85
Primary Registration District No. 1001
Registered No. 770
(d) Street No. St. Joseph's Hospital 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 58 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 1640 Dennis M. Carroll
(a) Residence, No. 403 A. St St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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.

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 Hazel Ellen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 25, 1881

7. AGE: Years 58 | Months 3 | Days 27 | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Railroad Employee
9. Industry or business in which work was done, as saw mill, bank, etc. C.G.W. Ry
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation 24

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carrollton, Mo.

FATHER
13. NAME Michael Carroll
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) (Unk) Ireland

MOTHER
15. MAIDEN NAME Unknown Hubbard
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) (Unk) America

17. INFORMANT William Carroll
(ADDRESS) 403 A. St

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Olivet DATE July 25, 1939

19. FUNERAL DIRECTOR (NAME) Tracy Barry Funeral Home
(ADDRESS) 2185 Olive St.

20. FILED July 27 1939 [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 22 1939 to July 22 1939
I last saw him alive on July 22 1939. Death is said to have occurred on the date stated above, at 5:04 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Coronary Thrombosis	7-22-39
94 hr	

Other contributory causes of importance:
Coronary Sclerosis

Name of operation — Date of —
What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — 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.
—
Manner of injury —
Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) H. Early 301 P.S. Staley, M. D.
(Address) St. Joseph Mo

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(Licensed Embalmer's Statement on Reverse Side)

Dr Carle
Phys Surg. 69.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Garth H. Smith, Registered Apprentice No. ..... working under my personal supervision.

Signed Garth H. Smith

Licensed Embalmer No. 3927

P. O. Address 218 S 10 St Jos

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

If this body is not embalmed, above space should be left blank.