

NOV 14 1939

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

36159
Do not use this space.

1. PLACE OF DEATH

(a) County GRUNDY Registration District No. 328
 (b) Township _____ Primary Registration District No. 3017 Registered No. _____
 (c) City TRENTON (d) Street No. _____ 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. 6 mos. - ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

KATIE CARROLL
 (a) Residence, No. 509 West 15th St 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

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF E. J. Carroll
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. about 76 years old
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housekeeper
 9. Industry or business in which work was done, as saw mill, bank, etc. none
 10. Date deceased last worked at this occupation (month and year) Nov 1937 11. Total time (years) spent in this occupation unknown

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 29 1939
 22. I HEREBY CERTIFY, that I attended deceased from May 30 1939, to June 28 1939
 I last saw her alive on about June 5 1939 Death is said to have occurred on the date stated above, at 11:42 a.m.
 The principal cause of death and related causes of importance were as follows:

Chronic Valvular Heart Disease
Arthritis Deformans and Chronic Bronchitis
 Date of onset not known

Other contributory causes of importance:
Arthritis Deformans and Chronic Bronchitis not known

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) Dr. Brooks, M. D.
 (Address) Trenton Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown Ireland 5

FATHER 13. NAME unknown 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 9

MOTHER 15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Mr. and Mrs. Trenton, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Catholic Cemetery DATE 6-30-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Davis Funeral Home Trenton, Mo

20. FILED 6-30, 1939 Gene D. Fair Local Registrar.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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RECEIVED.

District Health Officer No. 117

District File Number

139-1397

Date Filed

OCT. 27 1939

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

Robert B. Davis

Registered Apprentice No.

2-12

working under my personal supervision.

Signed

Raymond A. Davis

Licensed Embalmer No.

3424

P. O. Address

Trenton, Mo

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.)

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