

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20760**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **2377**

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Joseph Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Harriette I. CARROLL 640
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

4. Sex Female
 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Douglas R. Carroll c
 6. (c) Age of husband or wife if alive 39 years
 7. Birth date of deceased January 15th, 1898
 (Month) (Day) (Year)

8. AGE:
 Years 42 Months 4 Days 25
 If less than one day hr. min.

9. Birthplace: Marshall Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: 0

MOTHER FATHER
 { **12. Name:** William Brisbois
 { **13. Birthplace:** Marshall Missouri
 (City, town, or county) (State or foreign country)
 { **14. Maiden name:** Barbara Martin
 { **15. Birthplace:** Marshall Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Byron Cassell, sister,
 (b) Address: 5205 Bennington, K.C.Mo.

17. (a) Burial (b) Date thereof June 12 '40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Slater, Missouri

18. (a) Signature of funeral director: Hellody-McGille y
 (b) Address: K. C. Mo.

19. (a) June 11, 1940 (b) M. M. Crow
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3947 Norton Avenue
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 10th
 year 1940 hour 7:45 minute _____ a.m. m.

21. I hereby certify that I attended the deceased from
July 22-40, 19, to June 10-40, 19;
 that I last saw her alive on June 9-40, 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Prk tubercular dress -
with pelvic peritonitis
Due to: Pulmonary edema
Due to: 39 B

Other conditions: (Include pregnancy within 3 months of death)
Major findings: Cervical erosion & relaxed perineum
Of autopsy: as above

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) None
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature: Virnet McQuinn (M. D. or other)
 Address: 236 Maple St Date signed 6/11/40
 While at work? _____ (Specify type of place) (e) Means of injury !

Duration
PHYSICIAN
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 22 1945

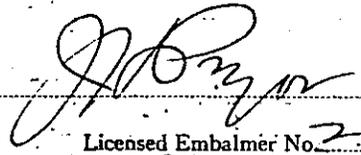
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____



Licensed Embalmer No. 2-759

P. O. Address _____

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.