

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 23 1942

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28601

State File No.

Registration District No. **318** Primary Registration District No. **1002** Registrar's No. **7722**

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St. Louis.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5506 Pershing Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community **60 Years.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County.....
(c) City or town **St. Louis.** (If outside city or town limits, write "RURAL")
(d) Street No. **5506 Pershing Ave.** (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Rose Carroll.**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F.** / 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Single.**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **Unknown** **1874**
(Month) (Day) (Year)

8. AGE: Years **68** Months **Unknown.** Days..... If less than one day hr. min.
9. Birthplace **Ireland.** (City, town, or county) (State or foreign country) **4**
10. Usual occupation **At Home.**

11. Industry or business.....
12. Name **Peter Carroll.**
13. Birthplace **Ireland.** (City, town, or county) (State or foreign country) **4**
14. Maiden name **Mary Smith.**
15. Birthplace **Ireland.** (City, town, or county) (State or foreign country) **4**

16. (a) Informant **Florence Carroll.**
(b) Address **5506 Pershing Ave.**
17. (a) **Burial.** (Burial, cremation, or removal) (b) Date thereof **9-19-42** (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery.**

18. (a) Signature of funeral director **Arthur Donnelly**
(b) Address **3840 Lambert**
19. (a) **SEP 16 1942** (Date received local registration) **J. J. Brudeck** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **16th.** year **1942.** hour **4.** minute **00** AM.
21. I hereby certify that I attended the deceased from **8/24/42**, 19....., to **9/16/42**, 19.....; that I last saw him alive on **9/8/42**, 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion**
Due to **ext. occlusion** **1 day**

Due to.....
Other conditions **Diets restricted (1 day)**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(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?
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **W. Back** (M. D. or other) **2nd**
Address **Humboldt Bldg** Date signed **9/16/42**

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

MOTHER FATHER

230100
230100

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lundell

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, fact should be so stated above.