

No. 2  
-8-43  
-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20515

State File No. \_\_\_\_\_

FILED JUL 15 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 2743

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: General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks (Specify whether  
16 years, (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48  
(c) City or town Kansas City, 3  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 2839 Wenzel  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country x D

3. (a) PRINT FULL NAME Thomas W. Carroll

3. (b) If veteran, name war no. 3. (c) Social Security No. 486-10-3894

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 30th  
year 1944 hour 6:00 minute \_\_\_\_\_ P. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mrs. Julia Carroll 6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased January 18 1889  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h Deputy Coroner and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
55 5 12 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Tuberculous meningitis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

10. Usual occupation Hooper,

Other conditions 14  
(Include pregnancy within 3 months of death)

11. Industry or business x

Major findings: Of operations \_\_\_\_\_

12. Name Abraham Carroll

13. Birthplace Michigan, (City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Bridges, (City, town, or county) (State or foreign country)

15. Birthplace Missouri, (City, town, or county) (State or foreign country)

Of autopsy See Above

16. (a) Informant Mrs. Julia Carroll,

(b) Address 2839 Wenzel, Kansas City, Mo.

17. (a) Removal (b) Date thereof 7-2-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Joplin, Missouri,

18. (c) Signature of funeral director Stins & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 7-1-44 (b) T. E. Brown  
(Date received local registry) (Registrar's Signature)

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 C. E. Washer (M. D. brother \_\_\_\_\_)

Address 2839 Wenzel Date signed 7/1/44

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**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. 1415

P. O. Address K. C. 1908

**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.**