V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 129

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 998

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Isolation Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Hours & 38 Minutes (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 000 10
(c) City or town St. Louis. 9
(If outside city or town limits, write "RURAL")
(d) Street No. 1466 Belt. 6
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Virgil Carroll.
3. (b) If veteran, name war Nil
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
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 March (Month) 8 (Day) 1914 (Year)

8. AGE: Years 30 Months 10 Days 17 If less than one day hr. min.

9. Birthplace Miller County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Harrison Carroll
13. Birthplace Miller County (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Opal Abbet
15. Birthplace Miller County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Harrison Carroll
(b) Address 1466 Belt Ave. St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation Crocker, Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) JAN 30 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January, day 25th year 1945 hour 12 minute 23 A.M.
21. I hereby certify that I attended the deceased from 1/21 1945, 19, to 1/24, 1945 that I last saw him alive on 1/24, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death acute streptococcus meningitis (not communicable)	3 days
Due to brain abscess	unk
Due to stenosis of tricuspid valve	
Other conditions congenital heart disease (Include pregnancy within 3 months of death) (unseparated aorta and pulmonary arteries)	life

Major findings:
Of operations
Of autopsy as above

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

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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? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. M. Feldman (M. D. or other)
Address 5531 Easton Ave Date signed 1/25 1945

(Licensed Embalmer's Statement on Reverse Side)

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933

FEB 16 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. 339

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, fact should be so stated above.