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DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED JUL 21 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25388

State File No.

Registration District No.

Primary Registration District No. **1003**

Registrar's No. **2506**

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:
5039 Beacon 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.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No. **5039 Beacon Ave.**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Richard W. Carroll**

3. (b) If veteran, name war.....

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 **January 8 1901**
(Month) (Day) (Year)

8. AGE: Years **46** Months **6** Days **0**
If less than one day hr. min.

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

10. Usual occupation **Deputy Sheriff**

11. Industry or business **City of St. Louis**

12. Name **Timothy A. Carroll**

13. Birthplace **Hannibal Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Augusta Scheppe**

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

16. (a) Informant **Timothy Carroll**

(b) Address **5039 Beacon Ave.**

17. (a) **Burial** (b) Date thereof **7/11/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Stroot-Carroll**
4600 Natural Bridge Ave.

(b) Address.....

19. (a) **JUL 9 1947** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8**
year **1947** hour **6** minute **30 P** M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw **1m** alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **Penetration of bullet into head, self-inflicted at his home, 5039 Beacon Ave. on July 8, 1947, about 5:30 p.m.**

Duration **5**

Due to **suicide while carrying gun**

Other cause of death **World War II**

(Include pregnancy within 3 months of death)

Major findings: Of operations..... **1647**

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 **suicide**

(b) Date of occurrence **July 8, 1947**

(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? **Home**

(Specify type of place)

While at work?..... (e) Means of injury **gun**

23. Signature **Patricia E. Taylor** (City, town, or county) **St. Louis**
Address **1300 Clark** Date signed **7-9-47**

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

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 *Ben Hoffman*
Licensed Embalmer No. *4366*
P. O. Address *St Louis, 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, fact should be so stated above.