

FILED FEB 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. 283

7045

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Wellston		c. LENGTH OF STAY (In this place) 28 yrs. 8 mos.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Sanitarium		d. STREET ADDRESS (If rural, give location) 7300 St. Charles Rook Rd.	
3. NAME OF DECEASED (Type or Print) Henrietta		a. (First) Henrietta	b. (Middle) Carroll
4. DATE OF DEATH (Month) (Day) (Year) Jan. 31 1951		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH April 17, 1884		9. AGE (In years last birthday) 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Thomas J. Carroll		13b. MOTHER'S MAIDEN NAME Emma Weis	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Sister - Miss Alice Carroll - 8 Portland Pk.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, unspecified, chronic INTERVAL BETWEEN ONSET AND DEATH 42 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Epilepsy with deterioration DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 29 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 35.33	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from May 20, 1922 , to Jan. 31, 1951 , that I last saw the deceased alive on Jan. 30, 1951 , and that death occurred at 7:25A m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Joseph A. Costello M.D.		23b. ADDRESS 7300 St. Char Rk Rd. St. Louis Mo 63115	
23c. DATE SIGNED 1/31/51		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE FEB. 2 1951		24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Herbert P. Donker	
DATE REC'D BY LOCAL REG. 2/1/51		ADDRESS 4386 Lindell	

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

4000

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 _____

working under my personal supervision.

Student Embalmer No.

Signed James A. Lammers

Signed
Student Embalmer

Licensed Embalmer No. 4142

P. O. Address St Louis

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.