

JAN 28 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

42407

1. PLACE OF DEATH **ST. LOUIS.**
County.....
Township..... **CARONDELET**
City..... (No..... Ward)

Registration District No. **1123**
Primary Registration District No. **6248**

File No.....
Registered No. **443**
St..... Ward)

2. FULL NAME **Marie Carroll**
(a) Residence. No. **North & Kings highway** Ward.....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Martin Carroll**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 6 - 1903**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
25 **6** **24**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Homemaker**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **St. Genevieve Mo**
(STATE OR COUNTRY)

10. NAME OF FATHER **Ben Rutter**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Mary Hooy**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Mo**
(STATE OR COUNTRY)

14. INFORMANT **Anna Rutter**
(Address) **5755 East Ave**

15. FILED **Dec. 30** 19 **L. C. Obrock M.D.**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **12-30** 19 **28**

17. I HEREBY CERTIFY, That I attended deceased from **11-27-28**, 19....., to **12-30**, 19 **28** that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... **10:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
238 31 (duration)..... yrs. mos. ds.

CONTRIBUTORY **Tubercular meningitis**
(SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Louis P. Brishniere**, M. D.
. 19 (Address) **9101 S. Broadway**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St. Genevieve Mo.** DATE OF BURIAL **12/30** 19 **28**

20. UNDERTAKER **Bosley V. Co.** ADDRESS **St. Genevieve Mo.**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

