

1939 SEP 14 791
1008

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: **1008**
(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **Apt. 905 Saum Hotel**
(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

3. (a) PRINT FULL NAME **Joanna Carroll 640**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **James A.** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **April 11 1867**
(Month) (Day) (Year)

8. AGE: Years **72** Months **3** Days **23** If less than one day hr. min.

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

10. Usual occupation **At Home**

11. Industry or business **5**
12. Name **William Hannigan**
13. Birthplace **Ireland**
(State or foreign country)
14. Maiden name **Joanna Hawe**
15. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **James Carroll**
(b) Address **Saum Hotel**
17. (a) **Burial** (b) Date thereof **Aug. 5 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery Cullinane Bros.**
18. (a) Signature of funeral director **1710 N. Grand Blvd.**
(b) Address

19. (a) **AUG 4 1939** (b) **J. D. Burdick**
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis Clayton** **NR**
(If outside city or town limits, write "RURAL")
(d) Street No. **7104 Forsythe Blvd.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **3rd**
year **1939** hour **2** minute **35** A. M.
21. I hereby certify that I attended the deceased from **May 10**
19**39** to **Aug 3** 19**39**
that I last saw her alive on **Aug 12** 19**39**
and that death occurred on the date and hour stated above.

Immediate cause of death **Prosecho-pneumonia 2 days**
Due to **Septicemia**
Due to **Coronary disease 3 mos**
Other conditions (include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 (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 **Walter Abel Jr** (M. D. or other)
Address **Easton Bldg** Date signed **8-3-39**

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.

1 X1931

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 *Fred Frick*.....

Licensed Embalmer No. *3186*.....

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, above space should be left blank.