

S. No. 2  
M-5-42  
7-5-17-39  
Y I 232272

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36140  
State File No. \_\_\_\_\_  
Registrar's No. **4121**

FILED NOV 19 1942  
Registration District No. 749

Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital 1 mo. & 8 days  
In this community 25 Years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 210 N. Monroe Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME Kate Elizabeth Carroll  
3. (b) If veteran, name war: No 3. (c) Social Security No. None  
4. Sex Female 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 October 6, 1859  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 5th year 1942 hour 8 minute 30 A.M.  
21. I hereby certify that I attended the deceased from 9-28-42, 19\_\_\_\_, to 11-5-42, 19\_\_\_\_; that I last saw her alive on 11-5-42, 19\_\_\_\_; and that death occurred on the date and hour stated above.

8. AGE: Years 83 Months 0 Days 30 hr. 29 min.  
9. Birthplace Unknown Connecticut  
(City, town, or county) (State or foreign country)  
10. Usual occupation At Home

Immediate cause of death Fracture of left femur-accidental fall in home; Arteriosclerotic heart disease  
Due to Nutritional anemia  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy None

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name William Carroll  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Amos Franke  
(b) Address 210 North Monroe Avenue  
17. (a) Burial Removal (b) Date thereof Nov. 7, 1942  
(Burial, cremation, or removal) St. John's Cemetery (Year)  
(c) Place: burial of Kansas City, Kansas  
18. (a) Signature of funeral director W. H. Newcomer, Sr.  
(b) Address 1401 Brush Creek Blvd.  
19. (a) 11-6-42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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 (specify) Acc  
(b) Date of occurrence Sept. 28 1942  
(c) Where did injury occur? K. C. Jack  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home  
While at work? \_\_\_\_\_ (Specify type of place)  
(2) Means of injury Fall  
23. Signature Amey R. Thorne (M. D. or other)  
Address ed. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

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**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 *K.C. Newman Jr.*

Licensed Embalmer No. 4043

P. O. Address K.C. Newman

**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.**