V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 31 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 128

Registrar's No. 619

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5143 Maffitt
(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) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17

(c) City or town St. Louis 96
(If outside city or town limits, write "RURAL")

(d) Street No. 5143 Maffitt Avenue,
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME KATHERINE CARROLL

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female 1

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife ----------

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March 1st 1879
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	10	17	hr. min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Matron

11. Industry or business City Infirmary

FATHER
12. Name Roger Carroll
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Katherine Brown
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret Engelland- Sister
(b) Address 5143 Maffitt Avenue,

17. (a) burial (b) Date thereof 1/22/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,
(b) Address 2849 North Euclid Avenue,

19. (a) JAN 22 1945 (b) J. F. Bridich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18th
year 1945 hour 8:30 minute P. M.

21. I hereby certify that I attended the deceased from 7-22-43, 19, to 1/17-45, 19;
that I last saw her alive on 1-17-45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to Hypertension

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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)

(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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature James A. Sullivan (M. D. ~~or other~~)

Address 2864 N Union Bl Date signed 1/19/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. James A. Sulliwan,
2864a No. Union Blvd.
Mu. 4422

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 Robert L. Brunkow

Licensed Embalmer No. 3553

P. O. Address.....

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.