

UNION DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. _____ Primary Registration District No. 1003

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

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: St. Louis City Hospital—Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether 0)
In this community 47 years
years, months or days)

3. (a) PRINT FULL NAME: JOHN CARROLL
3. (b) If veteran, name war: No--
3. (c) Social Security No. OAA

4. Sex: Male
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: May 11th, 1873
(Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 27
If less than one day hr. min.

9. Birthplace: Unknown Florida
(City, town, or county) (State or foreign country)
10. Usual occupation: OAA

MOTHER FATHER {
11. Industry or business: _____
12. Name: Henry Carroll
13. Birthplace: Unknown Florida
(City, town, or county) (State or foreign country)
14. Maiden name: Sarah Unknown
15. Birthplace: Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant: City Hospital Records
(b) Address: St. Louis, Missouri.
17. (a) Burial (b) Date thereof: 12-15-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park Cemetery
18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.
DEC 15 1948
19. (a) (Date received local registrar) (b) J. B. Foster (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County How
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: 3907 Delmar
Memorial 19 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 8th
year 1948 hour 3 minute 50 P.M.
21. I hereby certify that I attended the deceased from 12/6/48
to Dec. 8th 19 48
that I last saw him alive on Dec. 8th 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease
Duration: _____
Due to: 930
Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations: _____
Of autopsy: _____
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? 0
(Specify type of place)
While at work? _____ (e) Means of injury: _____
23. Signature: 1515 Lafayette (Date signed) 12/15/48
Address _____

10855

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 M. Murray

Licensed Embalmer No.

3749

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, fact should be so stated above.