

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31658

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7926

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission). a. STATE Missouri b. COUNTY 90		
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN ST Louis		c. LENGTH OF STAY (in this place) township)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST Louis		v143
d. FULL NAME OF HOSPITAL OR INSTITUTION 6324a Berthold			d. STREET ADDRESS (If rural, give location) 4 6324a Berthold.		
3. NAME OF DECEASED (Type or Print) a. (First) Virginia b. (Middle) Lee c. (Last) Carroll			4. DATE OF DEATH (Month) (Day) (Year) 9-8-1949		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH September 15, 1894	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ARKANSAS		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME LARKIN Johnston		13b. MOTHER'S MAIDEN NAME SARTIYA		14. NAME OF HUSBAND OR WIFE James W. Carroll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Moore 6324a Berthold		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Acute Pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH 9 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Generalized arteriosclerosis Conditions contributing to the death but not related to the disease or condition causing death. Hypertension		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 91		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4500		
22. I hereby certify that I attended the deceased from Aug 31, 1949, to Sept 7, 1949, that I last saw the deceased alive on Sept 7, 1949, and that death occurred at 8 a.m., from the causes and on the date stated above.					
23a. SIGNATURE Morten A. Dell MD.		23b. ADDRESS 7346 a Manchester		23c. DATE SIGNED 9-9-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-8-49	24c. NAME OF CEMETERY OR CREMATORY Foster Cemetery	24d. LOCATION (City, town, or county) (State) Arkansas		
DATE REC'D BY LOCAL REG. SEP 13 1949		REGISTRAR'S SIGNATURE J.B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.	

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

OCT 19 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

J. Allen Davis Jr

Licensed Embalmer No. *4083*

P. O. Address *St. Louis 1571*

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.