

FILED APR 5 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

10259

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2860**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hosp.		e. STREET ADDRESS (If rural, give location) 5047 S. Grand	
3. NAME OF DECEASED (Type or Print) a. (First) ELIZA b. (Middle) c. (Last) CARROLL		4. DATE OF DEATH (Month) (Day) (Year) March 25, 1950	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb 19, 1869
9. AGE (In years last birthday) 81 IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) Manchester England	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Adam Gerrard	
13b. MOTHER'S MAIDEN NAME Sarah Parker		14. NAME OF HUSBAND OR WIFE John Carrol	
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 John Parker Carroll 5047 S Grand			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease 1949x ANTECEDENT CAUSES DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Senility II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 42 B.C.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 14 , 19 49 , to March 25 , 19 50 , that I last saw the deceased alive on Mar. 25, 1950 , and that death occurred at 1:30am. , from the causes and on the date stated above.			
23a. SIGNATURE Jack R. Delman (Degree or title)		23b. ADDRESS 5400 Arsenal St.	
23c. DATE SIGNED 3/25/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 27, 1950	
24c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. MAR 27 1950		REGISTRAR'S SIGNATURE J. B. Sauter	
25. FUNERAL DIRECTOR'S SIGNATURE Glennard & Sons		ADDRESS 6175 Delman	

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 _____

Sam M. Seymour

Licensed Embalmer No. *01343*

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.