

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

9 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County St. Louis Registration District No. 784
Township St. Ferdinand Primary Registration District No. 6030
City Flouissant Mo. Rt 35 (No. Flouissant Mo. Rt 35)

File No. 15814
Registered No. _____
St. _____ Ward _____

2. FULL NAME

George W. Carriec

(a) Residence, No. Flouissant Mo. Rt 35, _____ Ward. _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Carriec

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 5 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 11 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Self.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) County

10. NAME OF FATHER Walter Carriec

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) County

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) unknown

14. INFORMANT Hiram H. Carriec
(Address) 1219 Beard Ave

15. FILED 4/27/29 19 29
O. W. Schuck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 24 1929

17. I HEREBY CERTIFY, That I attended deceased from April _____, 1929, to April _____, 1929, that I last saw him alive on April _____, 1929, and that death occurred, on the date stated above, at 9:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Angina Pectoris

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) G. J. Carriec M.D. MFD

4-25-1929 (Address) 1017 So. Campbell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cold Water Cemetery DATE OF BURIAL 4/26 1929

20. UNDERTAKER A. Kronk & Co ADDRESS 2707 N. Grand Blvd