

# CERTIFICATE OF DEATH

CLASS NO.

NO. OF RECORD

36496

CENSUS TRACT NO.

DISTRICT OF COLUMBIA HEALTH DEPARTMENT, BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH: (a) Street address 517 Great Falls (b) Name of hospital or institution \_\_\_\_\_ (c) Length of stay: In hospital or institution \_\_\_\_\_ (d) In District of Columbia \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASER: (a) State VA (b) County Fairfax (c) City or town East Falls Church (If outside city or town limits, write RURAL) (d) Street address 517 Great Falls (If rural give location) (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3. (a) FULL NAME (Print) William D. Carroll  
 (b) SOCIAL SECURITY NO. \_\_\_\_\_  
 (c) IF VETERAN, NAME WAR \_\_\_\_\_

4. SEX: fm 5. COLOR OR RACE: W 6. (a) SINGLE, MARRIED, WIDOWED, DIVORCED: Widowed  
 (b) NAME OF HUSBAND OR WIFE \_\_\_\_\_  
 7. BIRTH DATE OF DECEASED (Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. BIRTHPLACE Wash. D.C. (City, town or county) (State or foreign country)  
 10. USUAL OCCUPATION Retired

11. INDUSTRY OR BUSINESS \_\_\_\_\_  
 Father { 12. NAME (Print) Joseph Carroll  
 13. BIRTHPLACE Hydron (City, town or county) (State or foreign country)  
 Mother { 14. MAIDEN NAME (Print) Liza Carless  
 15. BIRTHPLACE Warland (City, town, or county) (State or foreign country)

16. (a) INFORMANT James Carroll  
 (b) ADDRESS East Falls Church  
 (c) RELATION OF INFORMANT TO DECEDENT Brother

17. (a) PLACE OF BURIAL, CREMATION, OR REMOVAL Congressional  
 (b) DATE June 30, 1942 (Month) (Day) (Year)

18. (a) Signature of funeral director Harry M. Sadler  
 (b) ADDRESS 131-11 N. S. O.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: June 28, 1942 (Month) (Day)  
 at 7 a. m. (State exact time of death)

21. I HEREBY CERTIFY that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 That I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
 Due to Hypertension  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include report of pregnancy within 3 months of death)  
 OPERATION: Name \_\_\_\_\_ Date \_\_\_\_\_  
 Major findings \_\_\_\_\_  
 Autopsy findings \_\_\_\_\_

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, in industrial place, in public place? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. SIGNATURE Macan Ware, Reg.  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

**IMPORTANT NOTICE.**—Failure to submit a Certificate of Death to the Health Department within forty-eight hours after the date of death is a violation of the laws of the District of Columbia. It is also a violation for any person or persons having custody of a body to hold it unburied for a longer period than one week after death. Violation of these laws is punishable by fine or imprisonment or both.

**THIS IS A PERMANENT RECORD. PLEASE FILL OUT WITH TYPEWRITER (EXCEPT SIGNATURES) OR WRITE PLAINLY WITH UNFADING INK.** Every item of information should be carefully supplied. AGE should be stated EXACTLY; if unknown, give approximate age. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. Space for remark may be found on the other side.