

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **10473**

City **St Louis** (No. **10473**)

Ward **19**

File No. **23157**

Registered No. **6616**

St. Ward)

2. FULL NAME

(a) Residence. No. **4475 W. Pine Bl.** St., **19** Ward.

(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

MEDICAL CERTIFICATE OF DEATH

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **May Conway**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 15 1865**

7. AGE YEARS **65** MONTHS **6** DAYS **2** IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. **Broker 131 82A** (b) General nature of industry, business, or establishment in which employed (or employer) **Bonds 89A** (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

10. NAME OF FATHER **Michael Conway**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

12. MAIDEN NAME OF MOTHER **Cassandra Hayes**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

14. INFORMANT **May Conway** (Address) **4475 W. Pine Bl.**

15. FILED **11 N 16 1931** REGISTRAR **May Conway**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 15, 1931**

17. I HEREBY CERTIFY, That I attended deceased from **May 9, 1931**, to **June 15, 1931**, and that I last saw him alive on **JUNE 15, 1931**, and that death occurred, on the date stated above, at **1:40 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS: **Apoplectic**
Arteriosclerosis - (Partial Hemiplegia)
Ch. atrophic Pharynx
Ch. hypertrophic Prostate
(duration) **2** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Ac Paulant Otitis Media - Ac. Mastoiditis**
Sinus thrombosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **82A**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **James T. Cummings**, M. D.

(Address) **220 Metro Station Bldg**

*States 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 **St Carmel Ill** DATE OF BURIAL **June 17 1931**

20. UNDERTAKER, **Hangan & Sheahan** ADDRESS **4415 Washington**

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.

STATE HEALTH DEPARTMENT, WITH CHANGING NUMBERS THIS IS A PERMANENT RECORD

