

REC'D FEB 10 1939

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

791  
100379  
Do not use this space.

## 1. PLACE OF DEATH

- (a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City..... St. Louis (d) Street No. City Hospital #1 St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 500 Arthur Conway

- (a) Residence, No. No Home St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
About 48

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unemployed  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.13. NAME Wm. J. Conway14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Philadelphia Pa.15. MAIDEN NAME Hattie Arlen16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky17. INFORMANT William Conway  
(ADDRESS) 8109 Madison St. L. Co. Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE National Cem. DATE 1/4/3919. FUNERAL DIRECTOR C. Hoffmeister U. & L. Co.  
(ADDRESS) 7814 S. Broadway20. FILED JAN 3 1939  
J. B. Bredish Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 1 1939 19

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw h..... alive on.....<sup>19</sup>..... Death is said to have occurred on the date stated above, at 3:15 P.M.

The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia

Other contributory causes of importance:

Chronic Diffuse Nephritis;Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? Yes23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury..... 19.....  
Where did injury occur?..... (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury.....  
Nature of injury.....24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify.....  
(Signed) Joseph M. Quinn M.D.  
(Address) Deputy Coroner

STATEMENT BY LICENSED EMBALMER

I, George W. Hoffmeister, Licensed Embalmer No. 2426

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E. ....

No. .... or by Neal C. Paulson, Registered Apprentice No. 139

working under my personal supervision.

Signed: George W. Hoffmeister

Licensed Embalmer No. 2426

**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.)**