

REC'D FEB 10 1939

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

215

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **731**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **5200 Winona Ave.** Registered No. **215**
(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

535 Mrs. Katherine Condon
(a) Residence, No. **5200 Winona Ave.** St. **14**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 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 **Late Joseph F. Condon**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 24, 1871**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 11 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. **Housewife**
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) **New Jersey**

FATHER 13. NAME **Dominic Flynn**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

MOTHER 15. MAIDEN NAME **Mary Rudie**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

17. INFORMANT **Joseph F. Condon Jr.**
(ADDRESS) **5200 Winona Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cem.** DATE **1-7** 19 **39**

19. FUNERAL DIRECTOR (NAME) **Kriegshauser Mortuary**
(ADDRESS) **4228 So. Kingshighway**

20. FILED 19 **J.F. Brudeck**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-5** 19 **39**

22. I HEREBY CERTIFY That I attended deceased from **Jan 19**, 19**37**, to **Jan 5**, 19**39**
I last saw her alive on **Jan 5**, 19**39**. Death is said to have occurred on the date stated above, at **5:50 P.M.**

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

Myocardial Degeneration Date of onset **1936**

Other contributory causes of importance:
arterial hypertension **1935**

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. 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) **S.A. West**, M. D.

(Address) **439 Bates St**

JAN 6 1939

Licensed Embalmer's Statement on Reverse Side)

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.

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

Registered Apprentice No....., working under my personal supervision.

Signed..... *Edwin A. McHerrett*

Licensed Embalmer No. 3024

P. O. Address.....

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, above space should be left blank.