

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

24044  
Do not use this space.

REC'D AUG 11 1939

1. PLACE OF DEATH  
 (a) County St. Louis Mo. Registration District No. 791  
 (b) Township St. Louis Mo. Primary Registration District No. 1008  
 (c) City St. Louis Mo. (d) Street No. City Hospital Registered No. 6317  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME THOMAS W CONLEY 540  
 (a) Residence, No. 2724 N. Jefferson St. 20 (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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) Julia Conley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT. 11 - 1917

7. AGE YEARS 21 MONTHS 09 DAYS 5 If LESS than 1 day, hrs. or min.

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

FATHER  
 13. NAME James Conley  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER  
 15. MAIDEN NAME Christiana Smith  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) John Conley 2724 N. Jefferson  
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis Mo. DATE 11-19-39  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Sullivan 2749 N. Gillies  
 20. FILED JUL 17 1939 J. F. Budesh Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/16 1939

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

I last saw him alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:  
Wound from Gun Shot  
Spine collapsed under  
pressure exerted in the  
hands of one Anthony  
 Other contributory causes of importance:  
Peritonitis in a tavern  
at 1025 W. St. Louis Ave  
about 10:25 P.M. July 16 - 1939

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? Yes

If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide ..... Date of injury .....  
 Where did injury occur? St. Louis Mo.  
 Specify whether injury occurred in industry, in home, or in public place. Public Place

Manner of injury .....  
 Nature of injury .....  
 24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify Yes  
 (Signed) Joseph M. D. D. D.  
 (Address) St. Louis Mo.

**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.....

Henry C. Trosesi....., Registered Apprentice No. 170  
working under my personal supervision.

Signed Albert Mayfield.....

Licensed Embalmer No. 3077

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.**