

1940 AUG 25 17 91
Registration District No. _____

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **City Hospital, #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Mo. 17 Days**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **2614 Arkansas**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Ben Conway** **500**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widowed**

6. (b) Name of husband or wife **Helen** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Feb. 27, 1864**
(Month) (Day) (Year)

8. AGE: Years **76** Months **5** Days **2** If less than one day
hr. _____ min. _____

9. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business _____

12. Name **? Conway**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary ?**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Louise Conklin**

(b) Address **2614 Arkansas**

17. (a) **Burial** (b) Date thereof **7/31/40**
(Burial, cremation, or removal) (City or town) (County) (State) (Month) (Day) (Year)
Lakewood Park Cem.

(c) Place: burial or cremation _____

18. (a) Signature of funeral director **Edith E. Ambruster**

(b) Address **4234 Manchester**

19. (a) **JUL 31 1940** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **29**,
year **1940** hour **3:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **June**
12, 19**40** to **July 29**, 19**40**

that I last saw him alive on **July 29**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Paroxysmal Atrial Fibrillation** Duration **2 yrs.**

Due to **Chronic Cardiac Insufficiency** **4 yrs.**

Due to **Generalized Arteriosclerosis** **20 yrs.**

Other conditions **Old Left Hemiplegia** **9 yrs.**
(Include pregnancy within 3 months of death)

Major findings: **Senility** **PHYSICIAN**

Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Walter Ford** (M. D. or other) _____

Address **1515 Lafayette** Date **7/29/40**

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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 John Fetter
Licensed Embalmer No. 3880
P. O. Address St. Louis, Mo.

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *24 D 11*

Registration District No.

Primary Registration District No.

Registrar's No. *6456*

1. PLACE OF DEATH:

(a) County *St. Louis*
(b) City or town *St. Louis*
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME *Ben Conway*

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *W*

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day . hr . min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *11-26-40* (Date received local registrar) (b) *J.P. Bredeck* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* day *29*-40
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____ *J. J. K.*

Due to _____

Other condition *Old St. Hemiplegia 7/27*
(Include pregnancy within 3 months of death)
following cerebral hemorrhage

Major findings: _____

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

OM

