

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

33834

8581

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No.

PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5601 Natural Bridge Ave
(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 **John Conrad**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **498-05-0694**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Amelia Arnsmeier Conrad** 6. (c) Age of husband or wife if alive **58** years
7. Birth date of deceased **Nov 7 1874**
(Month) (Day) (Year)

8. AGE: Years **65** Months **11** Days **7** If less than one day
hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

12. Name **Charles Conrad**

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

14. Maiden name **Magdalene Bender**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **John Conrad**

(b) Address **27286 Belt Ave**

17. (a) **Burial** (b) Date thereof **10/17/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Stroot - Carroll**

(b) Address **4600 Natural Bridge Ave**

19. (a) **OCT 15 1940** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5601 Natural Bridge Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **14th**
year **1940** hour **5** minute **10a** M.

21. I hereby certify that I attended the deceased from **Oct. 1**, 19**40** to **Oct. 14**, 19**40**
that I last saw him alive on **Oct. 14**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis (chronic)**

Due to **arteriosclerosis**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 **John J. Hanlon** (M. D. _____)

Address **1900 Belt** Date signed **10-14-40**

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

Sheldon Collier

Licensed Embalmer No. *3382*

P. O. Address

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.