No. 2
4-13-40
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 17 1941

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26651

Registrar's District No. 797 Primary Registration District No. 1003 Registrar's No. 6443

1. PLACE OF DEATH:

(a) County

(b) City or town City Hospital (If outside city or town limits, write "RURAL" and name of township)

(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 0 (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis Mo (If outside city or town limits, write "RURAL")

(d) Street No. 3855A Sherman Place (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

000 17 109

3. (a) PRINT FULL NAME Anastasia Connelly

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April (Month) 3 (Day) 1921 (Year)

8. AGE: Years 20 Months 4 Days 3 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

MOTHER FATHER

12. Name William Connelly

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

14. Maiden name Catherine Gillespie

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

16. (a) Informant Wm Connelly

(b) Address 4739 St Louis

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-1941 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Bros

(b) Address 2849 N. Euclid Ave

19. (a) AUG -7 1941 (Date received local registrar) (b) J. A. Fredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6 year 1941 hour 4:30 minute AM M.

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

Immediate cause of death Pneumonia Purulent left Adenitis Liver Abscess Duration

Due to August 3 1941

Due to About 10:30 pm while suffering temporary Hiccuffed Alfetralia

Due to Cardiac Arrest

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1634

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, homicide (specify) Suicide

(b) Date of occurrence Aug 3 1941

(c) Where did injury occur? Home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? No (e) Means of injury Poison

23. Signature Thomas F Callaghan (M.D. or coroner) Address Deputy Coroner Date signed 8/7/41

(Licensed Embalmer's Statement on Reverse Side)

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. Albert Mayfield

Licensed Embalmer No. 23077

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.