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 V. S. No. 2
 OM-9-4-41
 Rev. 5-17-39
 I X29484

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **4212**

FILED MAR 17 1942

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **1204**

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:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 8 Days
(Specify whether years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County..... 000

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

(d) Street No..... 919 N. Taylor Ave.
(If rural, give location)

(e) Citizen of foreign country?..... 0
(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Robert Conroy

3. (b) If veteran, name war..... Worlds

3. (c) Social Security No..... Don't know

4. Sex..... Male

5. Color or race..... White

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

6. (b) Name of husband or wife..... Mary Conroy

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

7. Birth date of deceased..... Jan. 1, 1891
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>1</u>	<u>5</u> hr. min.

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

10. Usual occupation..... Labor

11. Industry or business.....

MOTHER FATHER

12. Name..... Simon P. Conroy

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

14. Maiden name..... Katherine Gahagan

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

16. (a) Informant..... Mary Conroy

(b) Address..... Kankakee, Ill.

17. (a) Burial (b) Date thereof..... Feb. 9/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... St. Ann Cemetery

18. (a) Signature of funeral director..... Jos. W. Clark

(b) Address..... 1125 Hodiamont Ave.

19. (a) FEB 8 1942 (b) J. F. [Signature]
(Date filed local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... February day..... 6
 year..... 1942 hour..... 5:07 minute..... A. M.

21. I hereby certify that I attended the deceased from..... January 30, 1942, to..... February 6, 1942
 that I last saw him alive on..... February 6, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death..... Alcoholic psychosis

Duration..... months

Due to.....

Due to.....

Other conditions..... Fracture of feet
(Include pregnancy within 3 months of death)
caud infection

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) (b) Means of injury

23. Signature..... [Signature] (M., D. or other).....
 Address..... 1515 Lafayette Avenue Date signed..... 2/6/42

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.....



Licensed Embalmer No. 3225

P. O. Address 1125 Henderson Co. State

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.