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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1008

State File No.
Registrar's No. 11966

1. 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:
4468 Forrest Park Blvd. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Mo. (Specify whether
In this community 5 Mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Mo (b) County
(c) City or town St. Louis 1 19
(If outside city or town limits, write "RURAL")
(d) Street No. 4468 Forrest Park Blvd
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Louise Connell

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Nicholas W.

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased April 12th. 1893
(Month) (Day) (Year)

8. AGE: 52 Years ~~58~~ Months ~~11~~ Days 4 If less than one day hr. min.

9. Birthplace Ill 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name ?? Lerch
13. Birthplace U.S.A. 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace U.S.A. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Leontine Quigley
(b) Address 4462 Forrest Park Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45
(Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemt

18. (a) Signature Harrigan & Sheanan Und Co
(b) Address 4415 Washington Blvd.

19. (a) APR 19 1945 (b) J. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th.
year 1945 hour 9:22 A.M. minute M.

21. I hereby certify that I attended the deceased from May 1944, to April 1945
that I last saw her alive on April 16 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute dilatation of heart	24 hours
Due to Carcinoma of cervix	1 year
Due to General abdominal metastasis	8 mo.
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Ca. cervix metastasis pelvic glands
Of autopsy No

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

23. Signature S. Stein (M. D. or other)
Address 4487 Westminster Date signed 4-16

(Licensed Embalmer's Statement on Reverse Side)

1945

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. 2971

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, fact should be so stated above.