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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 21 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15024

Registration District No. 818 — Primary Registration District No. 1003 — Registrar's No. 4161

06
17
9
49

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4351 Laclede Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (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
(If outside city or town limits, write "RURAL")
(d) Street No. 4351 Laclede Ave.
(If rural, give location)
(e) Citizen of foreign country? U (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jermiah Concannon
3. (b) If veteran, name war
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Della Concannon
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Dec. (Month) 10 (Day) 1870 (Year)

8. AGE: Years 74 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Ireland (City, town, or county) U (State or foreign country)
10. Usual occupation Retired Insurance Broker
11. Industry or business

FATHER
12. Name John Concannon
13. Birthplace Ireland (City, town, or county) U (State or foreign country)

MOTHER
14. Maiden name Mary Manon
15. Birthplace Ireland (City, town, or county) U (State or foreign country)

16. (a) Informant Mrs. Della Concannon
(b) Address 4351 Laclede Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Sullivan Funeral Dir.
(b) Address 2849 No. Euclid Ave.
19. (a) MAY 10 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th. year 1945 hour 5:35 minute P. M.
21. I hereby certify that I attended the deceased from June, 1935 to 5-9, 1945; that I last saw him alive on 5-9, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Aspiration bronchitis — Pneumonia	4 day
Due to: General arteriosclerosis + cerebral softening	5 yrs.
Due to:	
Other conditions: None (Include pregnancy within 3 months of death)	

Major findings:
Of operations: None
Of autopsy: None

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 John J. Raymond (M. D. or other) M.D.
Address 634 N. Grand Date signed 5/10/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. John Hammond

Missouri Theatre Bldg. FR. 5080

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 Robert L Brinkman

Licensed Embalmer No. 3553

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.