V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 19 1945

State File No. 35146

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9640

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: 4264 Labadie Ave. 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 7
(If outside city or town limits, write "RURAL")

(d) Street No. 4264 Labadie Ave. 10
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME James Joseph Connors

3. (b) If veteran, name war Nil

3. (c) Social Security No. 489-18-9669

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Nettie Connors

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased November (Month) 17 (Day) 1870 (Year)

8. AGE: Years 74 Months 11 Days 16 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Retired Salesman

11. Industry or business

FATHER
12. Name Michael Connors
13. Birthplace (City, town, or county) Ireland (State or foreign country) 4

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Ireland (State or foreign country) 4

16. (a) Informant Louis Markwell
(b) Address 4479 St. Louis Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) NOV 6 1945 (Date received local registrar) (b) J. Medeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 3 year 1945 hour 9:00 minute P. M.

21. I hereby certify that I attended the deceased from Nov. 6, 1942, 19 to Nov. 3, 1945 that I last saw him alive on Nov. 3, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Cardiac Dilatation	12 hrs.
Due to Ch. Myocarditis	3 years
Due to Coronary Arteriosclerosis & Senility	Many years
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

92

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 James H. Cummins (M. D. or other) M. D.
Address 444 N. Euclid Date signed 11/6/45

(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 G. Hoffs

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.