S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35666

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9668

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:
City Infirmary 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months. (Specify whether
In this community 28 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 617
(If outside city or town limits, write "RURAL")

(d) Street No. 1405 N. Euclid 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Mulconry, Meta Elizabeth

3. (b) If veteran, name war NO

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Frank Mulconry (Deceased)

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

7. Birth date of deceased ~~1881~~ 10- (Month) 15 (Day) - 1881 (Year)

8. AGE: Years	Months	Days	If less than one day
64	0	22	hr. min.

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

10. Usual occupation Housewife

11. Industry or business --

FATHER
12. Name George ?
13. Birthplace Not known (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Not known
15. Birthplace " " (City, town, or county) 9 (State or foreign country)

16. (a) Informant City Inf. records
(b) Address 5800 Arsenal

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV-9-45 (Month) (Day) (Year)

(c) Place: burial or cremation NEW S.S. PETER + PAUL

18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette Av.

19. (a) NOV 8 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day sixth year 1945 hour 7: minute 22 P.M.

21. I hereby certify that I attended the deceased from July 2, 1945 to 11-6-, 1945; that I last saw her alive on 11-6-, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia 24 hrs., Chronic Myocarditis - 1945 Contr. Causes- Chronic Epilepsy -Grand Mal type - 20 years

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

93

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 Robin Prusin Bowdish (M. D. or other)

Address 5800 Arsenal St Date signed 11/7/45

(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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address St Louis Mo

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.