

FILED APR 30 1946

Primary Registration District No. 1003

Registrar's No. 2852

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 Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)
In this community 6 yrs.

3. (a) PRINTED FULL NAME Dr. Charles T. Mc.Connell

3. (b) If veteran, name war Unknown
3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced mar.
6. (b) Name of husband or wife Grace Mc.Connell
6. (c) Age of husband or wife if alive Unk. years
7. Birth date of deceased May 7 1876 (Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 19
If less than one day
.....hr.min.

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

10. Usual occupation Physician

11. Industry or business

12. Name John Wm. Mc.Connell
13. Birthplace W England
(City, town, or county) (State or foreign country)
14. Maiden name Julia Mixer
15. Birthplace Canada
(City, town, or county) (State or foreign country)

16. (a) Informant T. Singer
(b) Address 5400 Arsenal St.

17. (a) Burial (b) Date thereof 3-29-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia, Missouri

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

19. (a) MAR 26 1946 (b) J. F. Bredeek
(Date received local health officer's report) (Registrar's signature)

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. 5400 Arsenal St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1946 hour 7.30 minute A M.

21. I hereby certify that I attended the deceased from March 16, 1946 to March 26, 1946.
that I last saw him alive on March 26, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Degenerative Heart Disease 4yrs-x

Due to Arterial Hypertension

Due to Broncho Pneumonia 2 weeks

Cerebral Thrombosis 2 weeks

Other conditions.....
(Include pregnancy within 3 months of death)

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:

(c) 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).....
(e) Means of injury.....

23. Signature Revised Hofstatter (M. D. or other) M.D.
Address 5400 Arsenal Date signed 3/26/46

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

66929

844

Hofstatter

FRONT OF CARD

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

W. W. Wilkinson

Licensed Embalmer No. 3575

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.