

No. 2
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7-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 23 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42270
Registrar's No. 10099

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town St Louis
(c) Name of hospital or institution: Mo Pac Hospital
(d) Length of stay: In hospital or institution. (Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown (b) County 0870
(c) City or town Unknown 28
(d) Street No. Unknown
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country.....

3. (a) PRINT FULL NAME COLEMAN CONROY
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov 25 day 25
year 1946 hour 4 minute 20 P. M.
21. I hereby certify that I attended the deceased from 13 Nov
1946 to NOV 25 1946

4. Sex MO 5. Color or race W
6. (a) Single, widowed, married, divorced Unknown
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased April 14 1882
(Month) (Day) (Year)

that I last saw him alive on 25 NOV 25 4:20 P.M.
and that death occurred on the date and hour stated above.
Immediate cause of death Acute myocardial infarction Duration 1 day
Due to..... Potential due to Bronchial asthma
Bronchial

8. AGE: Years Months Days If less than one day
64 9 9 hr. min.

Due to..... 107
Other conditions (Include pregnancy within 3 months of death)
Major findings: Bladder obstruction
Organic Urethral strictures

9. Birthplace Ireland
10. Usual occupation Extra Gang Laborer
11. Industry or business Railroad
12. Name Unknown
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name..... (State or foreign country)
15. Birthplace (City, town, or county) (State or foreign country)

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)
Did injury occur in or about home, on farm, in industrial place, in public place?

MOTHER FATHER
16. (a) Informant Robert J. Ambrose
(b) Address 6633 Clayton Rd.
17. (a) burial (b) Date thereof 2-17-46
(c) Place: burial or cremation St. Joseph's Cemetery
18. (a) Signature of funeral director Robert J. Ambrose
(b) Address 6633 Clayton Rd.
19. (a) NOV 26 1946 (b) J. F. Bredecker
(Date received local registrar) (Registrar's signature)

23. Signature Louis J. Sutherland M. D. or other
Address Mo Pac Hosp. Date Nov 26 1946

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

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 *Arnold W. Schoene*
Licensed Embalmer No. *3864*
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.