

S. No. 2
-12-45
5-17-39
P I X47070

FILED MAR 24 1947
Registration District No. 318

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(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 Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(d) Street No. 4062 Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME AGNES CONNORS
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William Connors 6. (c) Age of husband or wife if 80 years
7. Birth date of deceased Nov 26, 1867
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 13th
year 1947 hour 12:45 minute P M.
21. I hereby certify that I attended the deceased 1/19/47
from 3/13/47 to 3/13/47, 19____; and that death occurred on the date and hour stated above.

8. AGE: 82 Years 3 Months 17 Days If less than one day _____ hr. _____ min.

Immediate cause of death Hypostatic pneumonia
Due to Atherosclerotic heart disease & senility
Due to _____

9. Birthplace Jefferson City, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Housewife

Other conditions Senile psychosis
Diabetes mellitus
(Include pregnancy within 3 months of death)

11. Industry or business _____
12. Name Mr. Hopie
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Mrs. Anne
15. Birthplace Germany (City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Julia Clark
(b) Address 4062 Memorial

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? ()

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/47 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park
18. (a) Signature of funeral director J. F. Breda
(b) Address 2849 No. Euclid
19. (a) WAR 14 1947 (Date received local registrar) J. F. Breda (Registrar's signature)

While at work Memorial (Specify type of place) Means of injury _____
23. Signature 1515 Lafayette Date signed 3/13/47 (other) _____
Address _____

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..... *Paul L. Dinkman*
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.