

PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
**FILED JUL 14 1948**

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. 21570  
Registrar's No. 1583

Registration District No. 377

Primary Registration District No. 3069

**1. PLACE OF DEATH:**  
(a) County St. Louis  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
7481 Wise Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

**3. (a) PRINT FULL NAME** Katherine Conway  
3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex F. 5. Color or race W.  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Joseph P. Conway  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased Jan. 21, 1870  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day  
78 4 3 hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

12. Name James Driscoll

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Hanora Mullen

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Ellen Conway  
(b) Address 7481 Wise Ave.

17. (a) Burial (b) Date thereof 6-27-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Danella  
(b) Address 3840 Lindel Blvd

19. (a) 6-25-48 (b) Carole J. Hays  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo. (b) County St. Louis  
(c) City or town Richmond Heights  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7481 Wise Ave.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month June day 24th,  
year 1948 hour 8 minute 15 P. M.  
21. I hereby certify that I attended the deceased from  
3-15-48, 19, to 6-24-48, 19;  
that I last saw him alive on 6-24-48, 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma left maxillary sinus  
Due to sarcoma left maxillary sinus  
Duration 4 mos  
Chr. Cardio-Vascular disease  
Other conditions Arterio-Sclerosis  
(Include pregnancy within 3 months of death) Chronic cardio-vascular arterio sclerosis  
Major findings:  
Of operations.....  
Of autopsy 552  
PHYSICIAN Chr. Chr.  
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?

While at work?..... (Specify type of place) (e) Means of injury.....  
23. Signature Carole J. Hays (M. D. or other)  
Address 2810 Sullivan Ave Date signed 6-25-48

2816  
H. B. 5-23  
2-5

**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 Stanley Marshall  
Licensed Embalmer No. 2868  
P. O. Address 3840 Lindell

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**