No. 2
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5-17-39

#85811

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 13 1948

Registration District No. 518

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 27601

Registrar's No. 7633

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

1. PLACE OF DEATH:

(a) County: St. Louis, Missouri.

(b) City or town: (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 Memorial (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 25 (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: St. Louis, Missouri County: 60d

(c) City or town: St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 808 N. 9th St. (If rural, give location) 9

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

If yes, name country

3. (a) PRINT FULL NAME: JOHN CONRAD

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male O

5. Color or race: White

6. (a) Single, widowed, married, divorced: Separated /

6. (b) Name of husband or wife: Johanna

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

7. Birth date of deceased: October (Month) 26th (Day) 1861 (Year)

8. AGE: Years 86 | Months 9 | Days 8 | If less than one day hr. min.

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

10. Usual occupation: O.A.A.

11. Industry or business:

FATHER
12. Name: Henry Conrad
13. Birthplace: Unknown (City, town, or county) (State or foreign country) ?

MOTHER
14. Maiden name: Elizabeth ?
15. Birthplace: Unknown (City, town, or county) (State or foreign country) ?

16. (a) Informant: Raymond Conrad

(b) Address: 4131a Lafayette Ave.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof AUG 31 1948 (Month) (Day) (Year)

(c) Place: burial or cremation: Anatomical Board

18. (a) Signature of funeral director: Rowland Mortuary-Service

(b) Address: 4104 Manchester Ave.

19. (a) AUG 31 1948 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th year 1948 hour 3 minute 10 P. M.

21. I hereby certify that I attended the deceased from 6/16/48, 19..., to August 4th, 19 48, that I last saw him alive on August 4th, 19 48 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: hypostatic pneumonia	2-3 wks.
Due to:	
Due to:	
Other conditions: (Include pregnancy within 3 months of death) Cardiac pathology	

Major findings:
Of operations:

Of autopsy:

PHYSICIAN — Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Paul M. Cadwell M.D. (M. D. or other)

Address: 4515 Lafayette 8/4/48 Date signed

Jefferson City Printing Co.

(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.....

Licensed Embalmer No.....

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.