

S. No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED OCT 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35079**
Registrar's No. **2021**

Registration District No. **277**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
80 Garden Drive
(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 Missouri (b) County St. Louis

(c) City or town Lemay
(If outside city or town limits, write "RURAL")

(d) Street No. 80 Lemay Garden Drive
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME John F. Connor

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased August 3, 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>2</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation Sales Manager

11. Industry or business Pher Manning Co.

12. Name Thomas Connor

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

14. Maiden name Pauline Lampe

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

16. (a) Informant Mrs. Heckman

(b) Address 4660 Korte Place

17. (c) Burial Oct 9, 1948
(Burial, cremation, or removal) (Date thereof) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Bromschwig and Son Funeral Home

(b) Address 4746 N. Florissant Ave.

19. (a) 10-8-48 (Date received local registrar) (b) Caul (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6
year 1948 hour 11 minute P M.

21. I hereby certify that I attended the deceased from 10-27, 1944 to 10-6, 1948
that I last saw him alive on 10-6, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary abscess Duration 3 years

Due to acute Respiratory infection common cold 33 days

Due to _____

Other conditions Syphillid ?

(Include pregnancy within 6 months of death)

Major findings: 30 g

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:

(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? 0

While at work? _____ (Specify type of place) Means of injury _____

23. Signature W. R. Gunn (M. D. or other) MD
Address 2227 S. Forward Date signed _____

10-8-48

DEC 23 1948

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 Aug W. Wilkinson
Licensed Embalmer No. 3575
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.