

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43275**
04641

FILED DEC 17 1949

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. _____	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY St. Louis		a. STATE Mo.		b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FENTON		c. LENGTH OF STAY (in this place) 15 YRS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FENTON		95	
d. FULL NAME OF HOSPITAL OR INSTITUTION FENTON, Mo.				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) Roy		b. (Middle) W	c. (Last) McCONNELL		(Month) Nov	(Day) 25	(Year) 1949
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 12-12-81		9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 Hrs. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) STILLWATER, MINN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JAMES McCONNELL		13b. MOTHER'S MAIDEN NAME ADELAIDE CARVER		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME St. Louis Co. Hospital, Clayton, Mo			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumia involving lower lobes both lungs					Unknown
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) Chronic bacterial infection					
		DUE TO (c) Unknown organisms					491X
		II. OTHER SIGNIFICANT CONDITIONS: Chronic atherosclerosis of coronary artery					Unknown
		Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 4-9-1949 to 11-12-1949 , that I last saw the deceased alive on 11-12-1949 , and that death occurred at 11:58 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE Arthur E. Keigel, M.D.				23b. ADDRESS 601 BRENTWOOD, CLAYTON, MO		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 12-9-49	24c. NAME OF CEMETERY OR CREMATORY Anatomical		24d. LOCATION (City, town, or county) (State) Wash Univ., St. Louis, Mo.		
DATE REC'D BY LOCAL REG. 12-9-49		REGISTRAR'S SIGNATURE Herbert R. Womke, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc ADDRESS 614 1/2 Manchester Ave. St. Louis 10, Mo			

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

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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_____

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

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.