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

FILED JUL 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22182

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 1519

1. PLACE OF DEATH
a. COUNTY: ST. LOUIS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CLAYTON
c. LENGTH OF STAY (in this place): 1 WEEK
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): COUNTY HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS 2037
d. STREET ADDRESS (If rural, give location): 6601 LINDENWOOD

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): A.
c. (Last): CONBOY

4. DATE OF DEATH (Month) (Day) (Year): JUNE 18, 1950

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: SEPT 3, 1897
9. AGE (In years last birthday): 52
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: PLAINING MILL
11. BIRTHPLACE (State or foreign country): ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: MICHAEL CONBOY
13b. MOTHER'S MAIDEN NAME: ELIZABETH DONIUS
14. NAME OF HUSBAND OR WIFE: AGNES G. CONBOY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WAR I
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT'S SIGNATURE OR NAME: AGNES G. CONBOY
ADDRESS: 6601 LINDENWOOD

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary Tuberculosis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 002X
20. AUTOPSY? YES ☒ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-10-, 1950, *to* 6-18-, 1950 *that I last saw the deceased alive on* 6-18-, 1950, *and that death occurred at* 4 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. R. Cohle, M.D. (Degree or title)
23b. ADDRESS: 601 BRENTWOOD CLAYTON
23c. DATE SIGNED: 6-19-50

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 6-21-50
24c. NAME OF CEMETERY OR CREMATORY: NAT. CEM. JEFF. BKS.
24d. LOCATION (City, town, or county) (State): ST. LOUIS MO.

DATE REC'D BY LOCAL REG.: 6-20-50
REGISTRAR'S SIGNATURE: Herbert L. Crowe
25. FUNERAL DIRECTOR'S SIGNATURE: M. J. Creagan
ADDRESS: 7116 Manchester

(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 _____

_____, working under my personal supervision.

Student Embalmer No. _____

Signed _____
Student Embalmer

Signed J. Allen Davis Jr.

Licensed Embalmer No. 4053

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.