

FILED FEB 23 1951
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5970
Registrar's No. 1382

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 5970		Registrar's No. 1382							
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ Mo b. COUNTY _____											
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.			c. LENGTH OF STAY (In this place) _____			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis. 2209									
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 20 2312 a St. Louis Av.											
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE			b. (Middle) _____			c. (Last) CONNORS			4. DATE OF DEATH (Month) (Day) (Year) Feb. 9th, 1951						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 10-5-1896		9. AGE (In years last birthday) 54		10. MONTHS _____		11. DAYS _____		12. HOURS & MIN. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) St. Louis, Mo.				12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME Michael Connors				13b. MOTHER'S MAIDEN NAME Nellie Stonson				14. NAME OF HUSBAND OR WIFE single							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. _____				17. INFORMANT'S SIGNATURE OR NAME Mrs Agnes Mc Call				ADDRESS 2312 a St. Louis			
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.				<p align="center">MEDICAL CERTIFICATION <i>CLAB REPORTS NOT RETURNED</i></p> <p align="center">I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis of Prostate & Bladder</u></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Old Arrested pulmonary Tuberculosis</u></p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p>								INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input 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? _____				0/6. X			
22. I hereby certify that I attended the deceased from <u>1/16/51</u> , 19 <u>51</u> , to <u>2/9/51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>2/9/51</u> , 19 <u>51</u> , and that death occurred at <u>3:45 AM</u> m., from the causes and on the date stated above.															
23a. SIGNATURE <i>J. B. Lasater</i>						23b. ADDRESS 1515 Lafayette Ave.,				23c. DATE SIGNED 2/9/51					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial				24b. DATE 2-12-51		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.					
DATE REC'D BY LOCAL REG. FEB 11 1951				REGISTRAR'S SIGNATURE <i>J. B. Lasater</i>				25. FUNERAL DIRECTOR'S SIGNATURE Goodhart & Goodhart				ADDRESS 2228 St. Louis Av			

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

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 Me

working under my personal supervision.

Student Embalmer No.....

Signed.....

Edward H. Remelius

Signed.....
Student Embalmer

Licensed Embalmer No. 4283

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.