

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 224

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Koch (rural)
c. LENGTH OF STAY (in this place) 77 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Robert Koch Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri
b. COUNTY _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis
d. STREET ADDRESS (If rural, give location) 6237 Clayton

3. NAME OF DECEASED (Type or Print)
a. (First) Conrad b. (Middle) John c. (Last) McCloskey
4. DATE OF DEATH (Month) (Day) (Year) 1-26-51

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH 2-17-85 9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME John McCloskey 13b. MOTHER'S MAIDEN NAME ?? UNKNOWN 14. NAME OF HUSBAND OR WIFE Emma Buskin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None 16. SOCIAL SECURITY NO. 29494-03-3812 17. INFORMANT'S SIGNATURE OR NAME Hospital Records, Robt. Koch Hosp. ADDRESS _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH ??
*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 DUE TO (b) _____
Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 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) 0-02 X

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ 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 11-10-1950, to 1-26-1951, that I last saw the deceased alive on 1-26-1951, and that death occurred at 8:55 Am., from the causes and on the date stated above.

23a. SIGNATURE Ellis D. Lipitz M.D. (Degree or title) 23b. ADDRESS Robert Koch Hospital 23c. DATE SIGNED 1-26-51

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE JAN. 29, 1951 24c. NAME OF CEMETERY OR CREMATORY CONCORDIA 24d. LOCATION (City, town, or county) (State) St. Louis MO

DATE REC'D BY LOCAL REG. 1/26/51 REGISTRAR'S SIGNATURE Herbert R. Tombs M.D. FURNERAL DIRECTOR'S SIGNATURE Street: Carroll 4600 Rail Bridge ADDRESS _____

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

4000

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.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed *Ben G. Lehman*

Licensed Embalmer No. *11366*

P. O. Address *St. Louis*

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.