

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34742

FILED OCT 23 1951

State File No.

BIRTH NO.		REG. DIST. NO. <u>306</u>		PRIMARY REG. DIST. NO. <u>6048</u>		Registrar's No. <u>18</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Peters</u>		c. LENGTH OF STAY (In this place) <u>Rural Residence</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Peters</u>		Rural		
d. FULL NAME OF HOSPITAL OR INSTITUTION				/d. STREET ADDRESS (If rural, give location) <u>0920</u>				
3. NAME OF DECEASED (Type or Print) <u>Jerome</u>			a. (First)		b. (Middle)		c. (Last) <u>Conoyer</u>	
4. DATE OF DEATH <u>10-14-51</u>		(Month) (Day) (Year)		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>12-19-1862</u>		9. AGE (In years, months, days) <u>88</u>		IF UNDER 1 YEAR: Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>St. Charles, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>John B. Conoyer</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Tayon</u>			14. NAME OF HUSBAND OR WIFE <u>Annie Conoyer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Chas. Schappe, St. Peters, Mo.</u>				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Edema</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>generalized Cardiovascular arteriosclerosis, carcinoma stomach</u> 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 <u>4221</u>				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)		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 <u>July</u> , 19 <u>50</u> , to <u>October</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Oct 14</u> , 19 <u>51</u> , and that death occurred at <u>2 p m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>George R. Esaki, M.D.</u>				23b. ADDRESS <u>St. Gallen, Mo.</u>		23c. DATE SIGNED <u>10-15-51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-17-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>All Saints</u>		24d. LOCATION (City, town, or county) (State) <u>St. Peters, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Oct 15 '51</u>		REGISTRAR'S SIGNATURE <u>E.A. Keithly</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Geo. Stiefvater, St. Peters, Mo.</u>				

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

920

File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT 18 1951

RECEIVED

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 _____

E. Keithly

Licensed Embalmer No. _____

P. O. Address _____

872
Fallow 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.