S. No. 300
v. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

LLD APR 18 1953

State File No. 15582

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3648

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

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

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) High Hill 0400
d. STREET ADDRESS (If rural, give location) /

3. NAME OF DECEASED (Type or Print)
a. (First) Mabel
b. (Middle)
c. (Last) Conran

4. DATE OF DEATH (Month) (Day) (Year) April 4 1953

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Nov. 22, 1881
9. AGE (In years last birthday) 71 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Middletown, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown.
14. NAME OF HUSBAND OR WIFE Thomas R. Conran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) — o —
16. SOCIAL SECURITY NO. 499-01-5994-A
17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary Drimped — ADDRESS 6342 Albertine

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) Carcinoma of bladder — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Generalized metastases — 2 mos.
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 181X

22. *I hereby certify that I attended the deceased from* Jan 25, 1952, *to* 4-4, 1953, *that I last saw the deceased alive on* 4-3, 1953, *and that death occurred at* 6 A *m., from the causes and on the date stated above.*

23a. SIGNATURE J. Weyrich (Degree or title) MD
23b. ADDRESS 8325 N. Broadway
23c. DATE SIGNED 4-4-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 4-7-53
24c. NAME OF CEMETERY OR CREMATORY St. Patricks Cem.
24d. LOCATION (City, town, or county) (State) Jonesburg Missouri

DATE REC'D BY LOCAL REG. APR 8 1953
REGISTRAR'S SIGNATURE J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE Central Funeral Home — ADDRESS 5541 Riverview Blvd.

(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.....

..... Student Embalmer No. .....,

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No. 4366

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.