

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17115**
Registrar's No. **4119**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri 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 OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION 6305 Virginia		e. STREET ADDRESS (If rural, give location) 6305 Virginia	

3. NAME OF DECEASED (Type or Print) Josephine C. Conroy			4. DATE OF DEATH May 6, 1954		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Mar. 12, 1883		9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Wm. Wetton		13b. MOTHER'S MAIDEN NAME Alice Murry	
14. NAME OF HUSBAND OR WIFE Wm. F. Conroy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT'S SIGNATURE OR NAME Alice Conroy		18. ADDRESS 6305 Virginia			

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chol. Nephritis				INTERVAL BETWEEN ONSET AND DEATH 6 mos	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General Sepsis		DUE TO (b) infected osteomyelitis				2 yrs	
		DUE TO (c) Arthritis of joints				9 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 725X	
22. I hereby certify that I attended the deceased from 5-1- , 19 54 , to 5-6- , 19 54 , that I last saw the deceased alive on 5-3- , 19 54 , and that death occurred at 1030a m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) L. F. Murray M.D.		23b. ADDRESS 605-A - Russell Blvd		23c. DATE SIGNED 5-6-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-8-54		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem.	
24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home			
DATE REC'D BY LOCAL REG. MAY 7 1954		REGISTRAR'S SIGNATURE [Signature]		ADDRESS 6322 S. Grand Blvd.	

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *David Van*

Licensed Embalmer No...42

P. O. Address 63228

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.