

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43803

State File No.

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

11440

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) ST. LOUIS		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.		e. STREET ADDRESS (If rural, give location) 22 806 Hickory 2229					
3. NAME OF DECEASED (Type or Print)		a. (First) JAMES		b. (Middle) P			
		c. (Last) McCONNELL		4. DATE OF DEATH (Month) (Day) (Year) DEC. 14 1954			
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2			
8. DATE OF BIRTH July 30 1876		9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days			
11. IF UNDER 1 YEAR Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo 0		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME James McConnell		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Elizabeth McConnell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Rowbotham 3318 Park			
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) <u>Broncho pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Benign prostatic hypertrophy</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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? 491X			
22. I hereby certify that I attended the deceased from 10:25:54, 19 to 12:14:54, 19, that I last saw the deceased alive on 12:14:54, 19, and that death occurred at 10:00 P.M., from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) Robert E. Thomson MD.				23b. ADDRESS 1515 LAFAYETTE		23c. DATE SIGNED 12-15-54	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Dec 20 54		24c. NAME OF CEMETERY OR CREMATORY National Park		24d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo	
DATE RECD BY LOCAL REG. DEC 15 1954		REGISTRAR'S SIGNATURE E. J. Schnur		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10-48

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.....

Licensed Embalmer No. 4014

P. O. Address 305 1st St

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.