

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038498

STATE FILE NUMBER

Health,  
& Welfare  
Public  
Service

S. 300  
Y. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2684

**FILED OCT 27 1958**

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mehlville</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Mehlville</b> <i>food</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rt 8 Box 1385</b> Length of stay in lb <b>5Yrs</b>		d. STREET ADDRESS (If outside, give location) <b>Rt 8 Box 1385</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen Gertrude McConnell</b> First Middle Last		4. DATE OF DEATH <b>Oct. 17th 1958</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887</b> <b>Dec. 23 1885</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>25</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St Louis 0</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Sidmon Collins</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Stritch</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>494-10-4252</b> <i>unit.</i>		17. INFORMANT <b>Mr William McConnell</b> Address <b>Rt 8 Box 1385 Mehlville Mo</b>	
18. CAUSE OF DEATH (Enter one cause per line by (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Myocardial Insufficiency</b> DUE TO (c) <b>Chc. Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4201</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 da</b> <b>3 yr +</b> <b>3 yr +</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e-g, in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>Jan 1, 1958</b> <b>10-17-58</b> and last saw her alive on <b>10.2.58</b> Death occurred at <b>899</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>F. J. Ryan M.D.</b>		22b. ADDRESS <b>2602 S. Brand</b>	
22c. DATE SIGNED <b>10-18-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Oct 20 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis Mo.</b>	
24. FUNERAL DIRECTOR <b>Fey Funeral Home, Mehlville Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>10-19-58</b>	
26. REGISTRAR'S SIGNATURE <b>Herbert R. Bond</b>			

(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..

Student.....  
Signature of Student Embalmer

Signed *Lawrence M. Bill*

Licensed Embalmer No. *43*

P. O. Address *St. Charles, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.