

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023647

FILED JUN 22 1959

Registration District No. 317 Primary Registration District No. 547  
STATE FILE NUMBER 59-023647 Registrar's No. 1599

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>Richmond Heights, Mo.</b>		Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Ferguson 4119</b>		Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Length of stay in lb. <b>4 Wks.</b>	d. STREET ADDRESS (If outside, give location) <b>232 Wesley</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>G.</b> Last <b>Conway</b>			4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1914</b>		9. AGE (In years, months, days, hours, minutes) <b>45</b> (In years, months, days, hours, minutes) IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS: Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chiropractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Industrial</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Charles Conway</b>		13b. MOTHER'S MAIDEN NAME <b>Agnes Monahan</b>		14. NAME OF HUSBAND OR WIFE <b>Ione</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>Yes W.W. II</b>		16. SOCIAL SECURITY NO. <b>487-20-5549</b>		17. INFORMANT Address <b>Ione Conway, 232 Wesley, Ferguson, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <b>Cirrhosis of the Liver</b> DUE TO (c) <b>5810</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Massive Gastrointestinal Bleeding - Esophageal Varices!</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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>11:45</b> Month, Day, Year <b>AM</b>					
20d. INJURY OCCURRED WHILE AT <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>December 22, 1958</b> to <b>June 11, 1959</b> and last saw him alive on <b>June 11, 1959</b> Death occurred at <b>11:45 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Robert N. Ramsey, M.D.</b>			22b. ADDRESS <b>25a S. Florissant, Ferguson, Mo.</b>		22c. DATE SIGNED <b>6/12/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-13-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe 4700 Washington, Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>6-12-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *G. W. Wilkinson*

Licensed Embalmer No. *3575*

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