

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025159

FILED VS JUN 20 1960

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1790 STATE FILE NUMBER

NDEB

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood 22, Mo.</u>		Length of stay in 1b <u>7 days</u>		c. CITY OR TOWN <u>Catawissa</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>General Delivery</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Alvina</u> Middle <u>---</u> Last <u>Conner</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> , Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/1881</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Oakfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Henry Fries</u>			13b. MOTHER'S MAIDEN NAME <u>Wilhelmima (Schultz) Fries</u>		14. NAME OF HUSBAND OR WIFE <u>Fred. M. Conner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Husband - Fred M. Conner</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.						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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m.	Month, Day, Year							
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 <u>Oct. 11, 1958</u> to <u>June 6, 1960</u> and last saw her alive on <u>June 5, 1960</u> Death occurred at <u>75</u> a <u>2</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Charles E. Hogenkamp, M.D.</u>				22b. ADDRESS <u>333 S. Kirkwood Rd., Kirkwood, Mo.</u>			22c. DATE SIGNED <u>June 8, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>		23b. DATE <u>6/9/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Cemetery</u>		23d. LOCATION (City, town, or county) <u>Catawissa, Mo.</u>			
24. FUNERAL DIRECTOR <u>Bell Funeral Home</u> Address <u>Pacific, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>6-9-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>		
<u>Byron J. Bell, Jr.</u>				(Licensed Embalmer's Statement on Reverse Side)				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
Byron J. Bell, Jr.

~~Student~~

~~Student Embalmer No.~~

working under my personal supervision.

~~Student~~

Signature of Student Embalmer

Signed

Byron J. Bell, Jr.

Licensed Embalmer No.

4977

P. O. Address

Pacific, 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.