

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3188 STATE FILE NUMBER 10606

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b <u>life</u> | c. CITY OR TOWN <u>St. Louis</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>6416 Colletta Drive</u> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | | |
|--|----------------------------------|---|--|---|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>JOSEPH</u> Last <u>CONN</u> | | | 4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1961</u> | | | |
| 5. SEX <u>male</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>10/10/32</u> | 9. AGE (last birthday) <u>28</u> | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fireman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>municipal</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | |
| 13a. FATHER'S NAME <u>William Conn</u> | | 13b. MOTHER'S MAIDEN NAME <u>Gertrude Rutledge</u> | | 14. NAME OF HUSBAND OR WIFE <u>Betty Boulch Conn</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Korean</u> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address <u>Mrs. Betty Conn, 6416 Colletta Drive</u> | | | |

| | | |
|--|---|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Thrombus abdominal aorta</u> | | <u>15 hrs</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Myocardial infarct</u> | <u>4 mos.</u> |
| | DUE TO (c) <u>arterio sclerosis general</u> | <u>1 year</u> |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | Month, Day, Year <u> </u> |
|---|------------------------------------|

| | | | | |
|--|--|------------------------------|--------|-------|
| 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 11-1-60 to 4/4/61 and last saw her/him alive on 4/4/61
Death occurred at 5:45 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|--|-----------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Eugene A Vogel MD</u> | 22b. ADDRESS <u>3325 S Grand St</u> | 22c. DATE SIGNED <u>4/4/61</u> |
|--|--|-----------------------------------|

| | | | |
|---|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Apr. 7, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u> |
|---|----------------------------------|--|---|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR ADDRESS <u>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</u> | 25. DATE RECD. BY LOCAL REG. <u>APR 5 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u> |
|--|---|--|

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

Dr. Vogel

3325 So. Grand

2-4 PM

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 Horner H. Jinty

Licensed Embalmer No. 3882

P. O. Address St. Louis

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.