

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007910

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2550**

STATE FILE NUMBER

AMENDED

Registration District No. **318**
FILED MAR 15 1962

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MISSOURI b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | c. CITY OR TOWN KIRKWOOD | |
| Length of stay in 1b 4 DAYS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MISSOURI | | d. STREET ADDRESS (If outside, give location) 210 NORTH TAYLOR | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | | | |
|-------------------------------------|----------------|-----------|---------------|------------------|--------------|----------|-------------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| | WILLIAM | G. | CONWAY | | MARCH | 2 | 1962 |

| | | | | | | | | |
|-----------------------|----------------------------------|---|-----------------------------------|-------------------------------------|---------------------------|------------------------|--------------------------|------------------------|
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6/9/97 | 9. AGE (last birthday) 64 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | IF UNDER 1 YEAR Hours | IF UNDER 24 HR Min. |
|-----------------------|----------------------------------|---|-----------------------------------|-------------------------------------|---------------------------|------------------------|--------------------------|------------------------|

| | | | |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) OFFICE EQUIPMENT (SERVICE) | 10b. KIND OF BUSINESS OR INDUSTRY --- | 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO. | 12. CITIZEN OF WHAT COUNTRY USA |
|---|---|---|---|

| | | |
|---|--|--|
| 13a. FATHER'S NAME WILLIAM CONWAY | 13b. MOTHER'S MAIDEN NAME MARGARET OFFUT | 14. NAME OF HUSBAND OR WIFE ELIZABETH CONWAY |
|---|--|--|

| | | | |
|---|---------------------------------------|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES | 16. SOCIAL SECURITY NO. WIT | 17. INFORMANT ELIZABETH CONWAY SEE 2C | Address |
|---|---------------------------------------|---|---------|

| | |
|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCT DUE TO (b) GENERALIZED METASTES DUE TO (c) CARCINOMA OF COLON | INTERVAL BETWEEN ONSET AND DEATH 153.8 |
|--|--|

| | |
|---|--|
| 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 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. Attended the deceased from 7:15 on 2/27/62 to 3/2/62 and last saw him alive on 3/2/62 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. |
|---|

| | | |
|---|--|-----------------------------------|
| 22a. SIGNATURE Stuart Meyer (Degree or title) M.D. | 22b. ADDRESS VAH, ST. LOUIS, MO. | 22c. DATE SIGNED 3/3/62 |
|---|--|-----------------------------------|

| | | | |
|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-7-62 | 23c. NAME OF CEMETERY OR CREMATORY National Cemetery | 23d. LOCATION (City, town, or county) (State) Jefferson Barracks, MO. |
|--|----------------------------|--|---|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR Boys Chapel, Kirkwood | 25. DATE RECD. BY LOCAL REG. MAR 6 1962 | 26. REGISTRAR'S SIGNATURE Carl Smith, M.D. |
|--|---|--|

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 SHOULD READ
 ITEM NO.

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 Francis J. Myland Jr

Licensed Embalmer No. 4512

P. O. Address Richmond, 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.