

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34498

Registration District No. 1009

Primary Registration District No. _____

Registrar's No. 9036

1. PLACE OF DEATH:

(a) County ENROUTE TO HOMER PHILIPS HOSP
 (b) City or town ST LOUIS MO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: NOV 15 1939

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days3. (a) PRINT FULL NAME CHARLIE CONNERS JR.3. (b) If veteran, name war NO3. (c) Social Security No. 499-01-13304. Sex MALE 5. Color or race COL.6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife ETHEL CONNERS6. (c) Age of husband or wife if alive 37 years7. Birth date of deceased SEPT 19 1897
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
42 1 3 hr. _____ min.9. Birthplace Crystal City (City, town, or county) (State or foreign country)10. Usual occupation PORTER11. Industry or business Baden Recreation12. Name CHAS CONNERS - SR.13. Birthplace TEX. (City, town, or county) (State or foreign country)14. Maiden name ELVIRA SMITH (City, town, or county) (State or foreign country)15. Birthplace St Louis MO (City, town, or county) (State or foreign country)16. (a) Informant's own signature Ethel Connors(b) Address 453 ANTELOPE17. (a) BURIAL (b) Date thereof 10-27-39
(Burial, cremation, or other) (Month) (Day) (Year)(c) Place: burial or cremation FATHER DICKSON CEMET18. (a) Signature of funeral director Bernice Love(b) Address 3103 Washington Ave19. (a) OCT 24 1939 (b) J. F. Miller
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 1(c) City or town St Louis MO (If outside city or town limits, write "RURAL") 8(d) Street No. 453 ANTELOPE St. (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
year 1939 hour 9 45 minute 0 A. M.21. I hereby certify that I attended the deceased from Oct 21
1939, to Oct 22, 1939that I last saw him alive on Oct 22, 1939
and that death occurred on the date and hour stated above.Immediate cause of death Pneumonia Duration 3 daysDue to T.B.C.

Due to _____

Other conditions NOT KNOWN
(Include pregnancy within 3 months of death)Major findings: Of operations noneOf autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no(b) Date of occurrence no

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

28. Signature H. F. Miller (M. D. or other)Address 8404 Osburn St Date signed 10/27/39

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Arthur L. Hilliard

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson

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 this body is not embalmed, above space should be left blank.