

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  
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41935  
State File No. 11058  
Registrar's No.

Registration District No. 737 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: 1000  
(a) County 1  
(b) City or town St. Louis, Missouri  
(c) Name of hospital or institution: City Hospital, #1  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Hrs.  
In this community 2 Hrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Baby Conley 540  
3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced X  
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased December 9, 1939  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
2 hr. 0 min.

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation X

11. Industry or business X

MOTHER FATHER  
12. Name Charles Conley  
13. Birthplace Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Bessie Phippen  
15. Birthplace Okla.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ann Morris  
(b) Address City Hospital, #1

17. (a) Cremation (b) Date thereof 12/25/39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director David Ann Phippen  
(b) Address City Hospital

19. (a) DEC 27 1939 (b) J. P. ...  
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County X  
(c) City or town St. Louis 23  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2608 S. 11th St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9,  
year 1939 hour 10:50 minute P. M.  
21. I hereby certify that I attended the deceased from December  
9, 1939 to December 9, 1939,  
that I last saw h. im alive on December 9, 1939,  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 151  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(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 \_\_\_\_\_  
23. Signature John F. Flynn (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette 12/13/39  
Date signed

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**