

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

41994

JAN 2 1940
Registration District No.

5221

Primary Registration District No.

Registrar's No.

11117

1. PLACE OF DEATH:

(a) County 1
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: City Hospital, #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 yr 6 mos. 7 Days
 In this community 8 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Thomas Connors 5623. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years7. Birth date of deceased June 22, 1868
(Month) (Day) (Year)8. AGE: Years 71 Months 5 Days 24 If less than one day hr. min.9. Birthplace Kentucky
(City, town, or county) (State or foreign country)10. Usual occupation Nil.11. Industry or business ---12. Name Warren Connors13. Birthplace Ireland
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Ann Morrison(b) Address City Hospital, #117. (a) (Burial, cremation, or removal) Washington (b) Date thereof 12-12-39
(Month) (Day) (Year)(c) Place: burial or cremation Washington18. (a) Signature of funeral director W. Richter(b) Address 3500 Patton19. (a) DEC 28 1939 (b) J. P. [Signature]
(Date received local registrar) (Date of death)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County X
 (c) City or town St. Louis, 25
 (If outside city or town limits, write "RURAL")
 (d) Street No. 507 Spruce
 (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 16,
year 1939 hour 10:00 minute A. M.21. I hereby certify that I attended the deceased from May
31, 1939 to December 16, 1939that I last saw him alive on December 16, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary Tuberculosis

Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

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 Edw. M. Pile (M. D. or other)
Address 1515 Lafayette, 12/6/39
Date signed

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.