DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20319

Registration District No. 791 JUL 17 1940 Primary Registration District No. 1003 Registrar's No. 5267

1. PLACE OF DEATH:

(a) County 2

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5638 Kingsbury (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 days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 5 (If outside city or town limits, write "RURAL")

(d) Street No. 5638 Kingsbury (If rural, give location)

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

3. (a) PRINT FULL NAME Robert T. Conroy 560

3. (b) If veteran, name war World War

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife *****

6. (c) Age of husband or wife if alive *** years

7. Birth date of deceased Unk April 29, 1892 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
About	48	1	18	hr. min.

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

10. Usual occupation Broker

11. Industry or business General Brokerage Business

FATHER
12. Name Patrick E. Conroy
13. Birthplace Mass (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Delia Moriarity
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature

(b) Address Maderia Ohio

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) JUN 17 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

No Physician ~~In Attendence~~

20. DATE OF DEATH: Month 16th day June year 1940 hour 2:30 minute A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Through and Through Ballet wound of Skull and Brain

Due to self inflicted at his home 5638 Kingsbury

Due to Cerk June-16-1940 about 2:35 A.M. while

Other conditions suffering temporary mental abberation (Include pregnancy within 3 months of death)

Major findings: Of operations Suicide

Of autopsy

Duration

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) Suicide

(b) Date of occurrence 6/16/40

(c) Where did injury occur? St Louis Mo (City or town) (County) (State)

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

While at work? (e) Means of injury

23. Signature Joseph M. Quinn (M. D. or other)

Address Deputy Coroner Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

I X19511

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.