DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30098

Registration District No. 7911 Primary Registration District No. 1003 Registrar's No. 7375

OCT 2

1. PLACE OF DEATH:

(a) County St. Louis

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

(d) Length of stay: In hospital or institution 1mo. 3days (Specify whether years, months or days)

In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. St. Louis 13
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal
(If rural, give location)

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

3. (a) PRINT FULL NAME Robert Conway

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

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 Unknown (Month) Unknown (Day) 1858 (Year)

8. AGE: Years 82 Months Days If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

FATHER 12. Name Richard Conway

13. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

MOTHER 14. Maiden name Elizabeth Gordon

15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant's own signature J. L. Sullivan

(b) Address 5800 Arsenal St.

17. (a) (Burial, cremation, or removal) (b) Date thereof 8-5-40 (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Ritter

(b) Address 3500 Ritter

19. (a) SEP 3 1940 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1940 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from August 24, 1939 to July 27, 1940 that I last saw him alive on July 27, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Degenerative	
Due to Heart Disease	
Due to Arteriosclerosis	
Other conditions (Include pregnancy within 3 months of death) 93C	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.

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 w the above constitutes grounds for revocation of license.)

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