

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 30498

Registration District No. 791

Primary Registration District No.

Registrar's No. 7775

1. PLACE OF DEATH:

(a) County _____
 (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 Sanitarium
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 29 yrs 8 mos 19 days No. 1
(Specify whether
 In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 13
(If outside city or town limits, write "RURAL")
 (d) days No. No Home 5400 ARSENAL ST
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William Connell

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov. 24 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	9	21	hr. _____ min.

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

10. Usual occupation Insurance Agent

MOTHER FATHER

11. Industry or business _____
 12. Name Michael Connell
 13. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Johanna Gleason
(City, town, or county) (State or foreign country)
 15. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant L. Siggendy

(b) Address City Sanitarium

17. (a) Burial (b) Date thereof 9-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation balvory Cullen Kelly

18. (a) Signature of funeral director _____
 (b) Address 1416 W. Taylor Ave

19. (a) SEP 18 1940 (b) _____
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14th,
 year 1940 hour 10:25 minute a.m. M.

21. I hereby certify that I attended the deceased from Nov. 1, 1939, 19____, to Sept. 14, 1940, 19____;
 that I last saw h. im alive on Sept. 14, 1940, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Arteriosclerotic Heart Disease
 Due to 11-1-39x

Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy No
 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 N. J. Bello (M. D. or other) M-D
 Address 5400 Arsenal St Date signed _____

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

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.....

working under my personal supervision.

Myself

....., Registered Apprentice No.....

*city of St. Louis
#145*

Signed.....

Wm E. Anderson

Licensed Embalmer No.....

4141

P. O. Address.....

St. Louis Mo.

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, fact should be so stated above.