

No. 2
4-13-40
5-17-39
P I X23159

MAY 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12554
State File No. _____
2984
Registrar's No. _____

Registration District No. 791

Primary Registration District No. 1003

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 49 E. Prairie
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Pete Connors
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 31
year 1941 hour 4:30 minute A. M.

4. Sex Male 5. Color or race Bel 6. (a) Single, widowed, married divorced Married
6. (b) Name of husband or wife Laura Connors 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased (Month) 3 (Day) 15 (Year) 1881

21. I hereby certify that I attended the deceased from March 28, 1941 to March 31, 1941
that I last saw him alive on March 31, 1941
and that death occurred on the date and hour stated above.

8. AGE: Years 61 Months 0 Days 16 If less than one day hr. _____ min. _____

Immediate cause of death Bronchial Asthma
Duration Several years

9. Birthplace Not known (City, town, or county) MO (State or foreign country)

Due to _____
Due to _____

10. Usual occupation Labors
11. Industry or business Not known

Other conditions (Include pregnancy within 3 months of death) 11 2

MOTHER FATHER
12. Name Not known 9
13. Birthplace (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

14. Maiden name Not known 4
15. Birthplace (City, town, or county) (State or foreign country)

16. Informant Mrs. Guel Sosa
(b) Address 929 Brookline

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) Fluential (b) Date thereof 4-5-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood

(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?

18. (a) Signature of funeral director J. P. Anderson
(b) Address 2625 S. Mass
19. (a) APR - 4 1941 (b) J. T. Bredek (Registrar's signature)

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Edith C. Cuitack (M. D. or other) 0
Address 2601 N. Whittier Date signed _____

3-31-41

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

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17
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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.....

W. Richards

Licensed Embalmer No. *2928*

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, fact should be so stated above.