. No. 2
—1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29425

Registration District No. 134 FILED SEP 8 1941

Primary Registration District No. 200

Registrar's No. 1660

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town KOCH Lemay (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 157 days (Specify whether

In this community 15 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 000

(c) City or town St. Louis 11 (If outside city or town limits, write "RURAL")

(d) Street No. 3051 Vinegrove 9 (If rural give location)

(e) Citizen of foreign country? No / (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MORRIS CONNER

3. (b) If veteran, name war

3. (c) Social Security No. 492-09-6524

4. Sex male

5. Color or race Negro

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Leola Harris (maiden)

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased August (Month) 16. (Day) 1905 (Year)

8. AGE:

Years	Months	Days	If less than one day
35	11	19	hr. min.

9. Birthplace Winona (City, town, or county) O Miss. (State or foreign country)

10. Usual occupation Porter

11. Industry or business

FATHER
12. Name Richmond Conner
13. Birthplace Vaiden (City, town, or county) O Miss. (State or foreign country)

MOTHER
14. Maiden name Sekey Omstes
15. Birthplace Vaiden (City, town, or county) O Miss. (State or foreign country)

16. (a) Informant Hospital Record.

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof 8-9-41 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Metropolitan F.H.

(b) Address 302 E. Dickson St.

19. (a) AUG 7 - 1941 (Date received local registrar) (b) E. J. McGauran M.D. (Registrar's signature)

AUG 7 - 1941 107

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4. year 1941 hour 2 minute 04 P.M.

21. I hereby certify that I attended the deceased from March 14, 1941, to August 4, 1941; that I last saw him alive on August 4, 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	6 months
Due to	+
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

B 41

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 Franz Steinberg (M. D. or other) O.M.D.

Address Robert Koch Hospital Date signed 8.4.41

(Licensed Embalmer's Statement on Reverse Side)

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 C. L. Townsend

Licensed Embalmer No. 2452

P. O. Address 3028 Dist

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.