

FILED JAN 20 1942

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 63

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koell Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 small days
(Specify whether

In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State St. Missouri (b) County St. Louis 016

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 40612 Mr. Ree 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ 1

3. (a) PRINT FULL NAME Thomas Michael Condon

3. (b) If veteran, name war _____

3. (c) Social Security No. 493-07-7541

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6
year 1942 hour _____ minute 1 P. M.

21. I hereby certify that I attended the deceased from July 1 P. M. 15, 1941 to January 6, 1942
that I last saw h. i. s. alive on January 6, 1942
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Gene Condon

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased November 21, 1888
(Month) (Day) (Year)

Immediate cause of death Pulmonary tuberculosis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy Pulmonary tuberculosis
gastro-entero-

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

61 1 16 _____ hr. _____ min.

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

10. Usual occupation Slave Seaman

11. Industry or business Isolation Hospital

12. Name Thomas Condon

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

14. Maiden name Margaret Fitzpatrick

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

16. (a) Informant Hospital Record

(b) Address Koch Hospital Koch Ho.

17. (a) Burial (b) Date thereof Jan 9 1942
(Burial, cremation, or removal) (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) JAN 8 - 1942 (b) C. H. Mc. Dawson
(Date received local registrar) (Registrar's signature)

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 Frank Steiner (M. D. or other) M.D.

Address Robert Koell Hospital Date signed 1-7-42

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

6000

Handwritten initials

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 Frank J. Owens

Licensed Embalmer No. 2245

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.