

Registration District No. **1943318**

Primary Registration District No. **1003**

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

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:
St. Luke's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **999**
(c) City or town **Trenton** **1 NR**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) **0**
(e) Citizen of foreign country? **2** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Kathleen Jo Conlee**

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

4. Sex **Female** / 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 **November 10, 1942**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 21 hr. _____ min.

9. Birthplace **Breese Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Child**

11. Industry or business _____

12. Name **William Harry Conlee**

13. Birthplace **Milwaukee Wisconsin**
(City, town, or county) (State or foreign country)

14. Maiden name **Josephine Deutsch**

15. Birthplace **Neillsville Wisconsin**
(City, town, or county) (State or foreign country)

16. (a) Informant **William Harry Conlee**

(b) Address **Trenton, Illinois**

17. (a) **Removal** (b) Date thereof **6/1/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Merriland, Wisconsin**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**

(b) Address **4700 Washington Blvd.**

19. (a) **JUN 1 1943** (b) **J. J. Bredich**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **31**
year **1943** hour **5:25** minute **0** P. M.

21. I hereby certify that I attended the deceased from **May 28**, 19**43**, to **May 31**, 19**43**

that I last saw her alive on **May 31**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Spina Bifida

Due to _____

Due to **151**

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

Major findings: Of operations **Same**

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? _____

While at work? _____ (Specify type of place) (Means of injury)

23. Signature **[Signature]** (M. D. or other) **M.D.**

Address **7953 Maryland** Date signed **6/1/43**

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..... *J. W. Wilkinson*
Licensed Embalmer No..... *3575*

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.