

FILED DEC 3 1948

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME MARY FRANCIS CONNORS

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Connors
6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased April 16 1876
(Month) (Day) (Year)

8. AGE: Years 67 Months 7 Days 8
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Lorene Connors

(b) Address Barnes Hospital

17. (a) Removal (b) Date thereof 11-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Frankfort, Ill.

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

(b) Address 4700 Washington Blvd.

19. (a) NOV 24 1948 (b) J. F. Brediek
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 24
year 1943 hour 9 minute 55 A.M.

21. I hereby certify that I attended the deceased from NOV. 8, 1943 to NOV. 24, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration 30 MIN.

Due to Cerebral arteriosclerosis _____ years

Due to _____

Other conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Hypertensive C-R. Disease
Major findings: Of operations None

Of autopsy Hypertrophied heart, brain NOT done, little aortic arteriosclerosis
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 M. C. Abney, M. D. (M. D. or other) _____

Address BARNES HOSPITAL Date signed 11/24/43

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

MOTHER FATHER

M 215

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

John Gromoski
2398

Licensed Embalmer No.....

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.