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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 3 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11579**

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. Louis City Hospital,
Max C. Starkloff Memorial**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day**
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **James M. Conlisk**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Mary Burke** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **October 7 1862**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 2 14 hr. min.

9. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)

10. Usual occupation **Plasterer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Patrick Conlisk**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Ann Mulhern**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Conlisk**
(b) Address **4344a Warne Ave.**

17. (a) **Burial** (b) Date thereof **12-24-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Cullinane Bros.**
(b) Address **1710 N. Grand Blvd**

19. (a) **DEC 22 1943** (b) **J. F. Bredack**
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL") **9 26**
(d) Street No. **1624 N. 18th St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **21**,
year **1943** hour **4:25** minute _____ P. M.

21. I hereby certify that I attended the deceased from **December 20, 1943** to **December 21, 1943**
that I last saw him alive on **December 21, 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Branchiopneumonia
Ca. of Bladder & metastasis
Bilateral hydrocephalus and
Due to **Hydrocephalus**** Duration _____

Due to _____
Due to **57**
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy **AS Above** **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)
(c) Means of injury _____
23. Signature **William J. Darr** (M. D. or other) _____
Address **1515 Lafayette Avenue,** Date **12/22/43**

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

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 *Howard P Rowland*

Licensed Embalmer No. *3114*

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.