

2
-43
7-39
K36971

FILED MAR 27 1944 **818**

Registration District No. **818** Primary Registration District No. **1003**

Registrar's No. **2616**

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:
#16 PARKLAND PLACE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... **31 YEARS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME..... **MARIA A. CONROY**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced..... **WIDOW**

6. (b) Name of husband or wife..... **THOMAS F. CONROY** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... **DONT KNOW** **1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 **UNKNOWN** hr. min.

9. Birthplace..... **IRELAND** 4
(City, town, or county) (State or foreign country)

10. Usual occupation..... **AT HOME**

11. Industry or business.....

12. Name..... **RALPH SATCHWELL**

13. Birthplace..... **IRELAND** 4
(City, town, or county) (State or foreign country)

14. Maiden name..... **MARY E. RABBITT**

15. Birthplace..... **IRELAND** 4
(City, town, or county) (State or foreign country)

16. (a) Informant..... **WILLIAM CONROY**

(b) Address..... **# 16 PARKLAND PLACE**

17. (a) **MARIA** (b) Date thereof..... **3-20-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **CALVARY CEMETERY**

18. (a) Signature of funeral director..... **Arthur J. Dorell**

(b) Address..... **3840 Linfield Blvd**

19. (a) **MAR 19** (b) **J. F. Budeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **MO** (b) County.....
(c) City or town..... **ST. LOUIS AND PLACE** **95**
(If outside city or town limits, write "RURAL")
(d) Street No. **16 BARKLAND PLACE**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **17**, year **1944** hour **7** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **Mar 1** 19**44** to **Mar 17** 19**44** and that death occurred on the date and hour stated above.

Immediate cause of death..... **Chronic pyelocystitis with arterio-sclerosis** Duration

Due to..... **93**

Other conditions..... **Chronic Bronchitis**
(Include pregnancy within 3 months of death)
(Both male)

Major findings: Of operations.....

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)..... **200**
(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..... **J. F. Budeck** (M. D. or other)
Address..... **4901 E. Easton Ave** Date signed **3/18/44**

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

MOTHER FATHER

4901
1-3
Gordon

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.