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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 3 1947**  
#67648

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **6132**  
Registrar's No. **1783**

Registration District No. **318** 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. Louis City Hospital—Max C. Starkloff  
(If not in hospital or institution, write street number or location) Memorial  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... years, months or days)

**3. (a) PRINT FULL NAME.** MARY CONLISK  
**3. (b) If veteran,** No **3. (c) Social Security**  
name war..... No. None

**4. Sex** Female **5. Color or** **6. (a) Single, widowed, married,**  
White race Widow  
**6. (b) Name of husband or wife** **6. (c) Age of husband or wife if**  
James M. Conlisk alive..... years  
**7. Birth date of deceased** January 12 1868  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day  
79 1 8 hr. min.

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

**10. Usual occupation** At Home

**11. Industry or business**

**12. Name** Thomas Burke

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

**14. Maiden name** Don't know

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

**16. (a) Informant** Mrs. May Wadsack,

**(b) Address** 4344a Warne Ave.

**17. (a) Burial** **(b) Date thereof** 2-22-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Calvary Cemetery

**18. (a) Signature of funeral director** Cullinane Bros.

**(b) Address** 3320 N. Kingshighway Blvd.

**19. (a) FEB 21 1947** **(b) J. J. Bredeck**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State..... Missouri (b) County.....  
(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2002 1/2 Cass Ave.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Feb. day 20th  
year 1947 hour 5:30 minute A M.  
**21. I hereby certify that I attended the deceased from** 1/29/47  
19, to 2/20/47, 19;  
that I last saw her alive on 2/20/47, 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure 12 hrs  
Due to Arteriosclerosis &  
Probable Coronary Occlusion

Due to.....  
Other conditions (include pregnancy within 3 months of death).....  
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).....  
(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)  
**23. Signature** Albert T. Madigan, M.D. 1515 Lafayette 2  
Address..... Date signed.....

*male*

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**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 *Fred Frick*.....

Licensed Embalmer No..... *3186*.....

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.**