

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13678**  
**3645**  
Registrar's No. \_\_\_\_\_

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sainta Louis Park</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6447 a West Park</b>		d. STREET ADDRESS (If rural, give location) <b>6447 a West Park</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Frank</b> b. (Middle) <b>G.</b> c. (Last) <b>Connor</b>			4. DATE OF DEATH <b>April 21, 1949</b> (Month) (Day) (Year)
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 3 1897</b>
9. AGE (In years last birthday) <b>51</b>		IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>John Boyle &amp; Co.</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13a. FATHER'S NAME <b>Frank Connor</b>	
13b. MOTHER'S MAIDEN NAME <b>Anna Dalton</b>		14. NAME OF HUSBAND OR WIFE <b>Alice M. Halleran Connor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>488-03-2596</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Alice Connor</b>
17. ADDRESS <b>6447 a West Park</b>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>Coronary Occlusion</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Coronary Calcification</b>	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>H201</b>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>no</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Feb 10, 1949</b> , to <b>Apr 21, 1949</b> , that I last saw the deceased alive on <b>Apr 19, 1949</b> , and that death occurred at <b>11:45</b> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Ernest O'Connell M.D.</b>		23b. ADDRESS <b>6347 Grand - St Louis Mo</b>	23c. DATE SIGNED <b>4/22/49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>4-25-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
DATE REC'D BY LOCAL <b>APR 23 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Pasater</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>M. J. Croghan &amp; Sons</b>	
		ADDRESS <b>7146 Manchester Ave.</b>	

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

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male

**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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_

Signed

*J. Allen Davis*  
Licensed Embalmer No. *7053*  
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.