

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20325

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4789**

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|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2209 | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI | | c. CITY OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL | | e. STREET ADDRESS (If rural, give location) 20 2519a Farrar St. | |

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|--|-------------|-------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) ROSELLA | b. (Middle) | c. (Last) CONLON | 4. DATE OF DEATH (Month) (Day) (Year) MAY 28, 1954 |
|--|-------------|-------------------------|--|

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|----------------------|-------------------------------|---|--------------------------------------|--|------------------------|-----------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct. 2, 1887 | 9. AGE (In years last birth day) 66 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours Min. |
|----------------------|-------------------------------|---|--------------------------------------|--|------------------------|-----------------------------|

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|---|-----------------------------------|--|------------------------------|
| 10a. USUAL OCCUPATION (The kind of work done during most of working life, even if retired) At Home | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 1 | 12. CITIZEN OF WHAT COUNTRY? |
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| 13a. FATHER'S NAME Patrick Dunn | 13b. MOTHER'S MAIDEN NAME Johanna Lee | 14. NAME OF HUSBAND OR WIFE John Conlon |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. No | 17. INFORMANT'S SIGNATURE OR NAME John Conlon, 2519a Farrar St. | ADDRESS |
|---|-----------------------------------|--|---------|

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) |
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| | | |
|--|---|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 4200 |
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22. I hereby certify that I attended the deceased from **5-25-54**, 19___, to **5-28-54**, 19___, that I last saw the deceased alive on **5-28-54**, 19___, and that death occurred at **8:15A** m., from the causes and on the date stated above.

| | | |
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| 23a. SIGNATURE Richard F. Jette M.D. (Degree or title) | 23b. ADDRESS 1515 Lafayette Avenue | 23c. DATE SIGNED 5-28-54 |
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|---|---------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 6-1-1954 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
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| DATE REC'D BY LOCAL REG. MAY 29 1954 | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullinane Bros. 3320 N. Kingshighway |
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 Student Embalmer No. working under my personal supervision. .

Student.....
Signature of Student Embalmer

Signed.....
Fred Frick

Licensed Embalmer No....3186..

P. O. Address...St..Louis,...

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.