

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022784

STATE FILE NUMBER

2 5903

FILED JUL 2 1959 Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. JOHN'S HOSPITAL</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>4460 NEOSHO</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>J</b> Last <b>CONNORS</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>20</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 14, 1880</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.
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>HAT COMPANY</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>JOHN CONNORS</b>		13b. MOTHER'S MAIDEN NAME <b>MARY MURPHY</b>		14. NAME OF HUSBAND OR WIFE <b>MARTHA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>488-01-4103</b>	17. INFORMANT Address <b>MARTHA CONNORS 4460 NEOSHO</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of left ventricle striate artery with cerebral infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>?</b>
DUE TO (b) <b>Arterio sclerotic vasculosis</b>		
DUE TO (c) <b>332x</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Perniciuous Anemia for years</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <b>No No No</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>May 28, 1959</b> to <b>June 20-59</b> and last saw <del>him</del> <b>him</b> alive on <b>June 28-59</b> Death occurred at <b>10:45 P.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>John J. Hammond M.D.</b>	22b. ADDRESS <b>634 N. Grand</b>	22c. DATE SIGNED <b>6/22/59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>6/23/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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24. FUNERAL DIRECTOR <b>J L ZIEGENHEIN &amp; SONS</b>	ADDRESS <b>7027 GRAVOIS</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 22 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Ronald E Benz* .....

Licensed Embalmer No. *4852* .....  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.