

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

-60-029174
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2298

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST LOUIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pine Lawn, Mo</u> | | Length of stay in lb <u>11 Years</u> | c. CITY OR TOWN <u>Pine Lawn</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shamrock Nursing Home</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3709 Manola Ave.</u> |

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| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Conlon</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1960</u> | | |
| 5. SEX <u>Female</u> | | | 6. COLOR OR RACE <u>White</u> | | |

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| 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-14-1882</u> | 9. AGE (last birthday) <u>77</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Worker</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Boyd Welsh Shoe Co.</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Martin Conlon</u> | 13b. MOTHER'S MAIDEN NAME <u>Ellen Reynolds</u> | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>489-05-5139 A</u> | 17. INFORMANT <u>Mrs R. E. Bauer, 4548 Queens Avenue</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> | | <u>unknown</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Hypertensive Heart disease</u> | <u>unknown</u> |
| | DUE TO (c) <u>Arteriosclerotic Heart disease</u> | <u>unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old hemiparesis (Cerebral thrombosis)</u> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> | Month, Day, Year <u> </u> / <u> </u> / <u> </u> |
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| 20d. INJURY OCCURRED WHILE AT WORK <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 |
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| 21. I attended the deceased from <u>Oct 20, 1949</u> to <u>July 30, 1960</u> and last saw her alive on <u>7/27/60</u> | Death occurred at <u>6:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>Lewis L. Schumann MD</u> (Doctor or title) | 22b. ADDRESS <u>8231 Clayton Rd (17)</u> | 22c. DATE SIGNED <u>8/1/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>8-2-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u> (State) |
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| 24. FUNERAL DIRECTOR <u>Math. Hermann & Son Inc. 2161 E. Fair Ave.</u> | 25. DATE RECD. BY LOCAL REG. <u>8-1-60</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy Md.</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John W. Hobbs

Licensed Embalmer No. *3731*

P. O. Address *S. Lane*

*Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.