

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 1 0 1960

=60-039634
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10588

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 _____				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b _____		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fiermin Desloge Hosp</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6811a Michigan Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Eugene</u> Last <u>Conrad</u>				4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1960</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>John Conrad</u>			13b. MOTHER'S MAIDEN NAME <u>Angelique L'Ange</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>403-10-5099</u>		17. INFORMANT <u>Leo Henkenius</u>		Address <u>6414 Virginia Ave.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA, suspected</u> DUE TO (b) <u>Bilateral BRONCHO PNEUMONIA</u> DUE TO (c) <u>491x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Renal insufficiency and anemia</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____								
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 _____		
21. I attended the deceased from <u>10-25-60</u> to <u>10-31-60</u> and last saw her <u>him</u> alive on <u>10-31-60</u> Death occurred at <u>2:45 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Max J. Irman MD</u> (Degree or title)				22b. ADDRESS <u>1325 S Grand</u>		22c. DATE SIGNED <u>11-1-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-3-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		23d. LOCATION (City, town, or county) <u>Lensay, Missouri</u>		(State) _____		
24. FUNERAL DIRECTOR <u>Fendler Und. Co.</u> ADDRESS <u>7420 Michigan Ave.</u>			25. DATE RECD. BY LOCAL REG. <u>NOV 2 1960</u>		26. REGISTRAR'S SIGNATURE <u>Leon Smith, M.D.</u>			

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

W. J. Petersen

Licensed Embalmer No. 376

P. O. Address: 7420 M

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.