SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-006402
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1762

FILED VS MAR 1 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Mo
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis Mo
Length of stay in 1b: 2-days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Lukes Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN: St Louis Mo
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4616 Lindell Blvd
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Michael Middle D Last Conroy
4. DATE OF DEATH: Month 2 Day 20 Year 61
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9-11-1881
9. AGE (last birthday): 79
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): Retired Vice President
10b. KIND OF BUSINESS OR INDUSTRY: Granite City Steel
11. BIRTHPLACE (City and state or country): Youngstown Ohio
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Stephen Conroy
13b. MOTHER'S MAIDEN NAME: Catherine Cavanaugh
14. NAME OF HUSBAND OR WIFE: Single
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James L.Hamilton # 55 Address: Loren Woods Ladue 24

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 550.1
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): General peritonitis – acute appendicitis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 2/19/61 about 6AM to 9:30 PM and last saw ~~her~~ him alive on 2/20/61
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): George B Rader M.D.
22b. ADDRESS: 457 N. Kingshighway
22c. DATE SIGNED: 2/21/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-23-1961
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St Louis Mo
24. FUNERAL DIRECTOR: Arthur J. Donnelly ADDRESS: 3840 Lindell Blvd
25. DATE RECD. BY LOCAL REG.: FEB 21 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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 Francis Wilkinson

Licensed Embalmer No. 3565

P. O. Address 3840 Linde

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.