

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033530

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8419** STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

FILED AUG 22 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 22 weeks	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2537 University Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First John Middle N. Last Conway	4. DATE OF DEATH Month 8- Day 17- Year 1963
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5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-28-1905	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Driver	10b. KIND OF BUSINESS OR INDUSTRY J. Arthur Anderson	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Stephen Conway	13b. MOTHER'S MAIDEN NAME Lydia Norton	14. NAME OF HUSBAND OR WIFE Mary Conway
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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) No	17. INFORMANT Address Mary Conway 2537 University Street
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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 3 MONTHS
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNGS		
Conditions, if any, which give rise to above cause (a), stating the underlying cause last.	DUE TO (b) CARCINOMA RIGHT KIDNEY	
	DUE TO (c) 180X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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 7/23/60 to 8/17/63 and last saw ^{her} him alive on 8/17/63 Death occurred at 5:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Carl W. Jamieson, M.D.	22b. ADDRESS 6000 WEST FLORISSANT	22c. DATE SIGNED 8/19/63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-20-1963	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) 5239 W. Florissant St. Louis, Mo
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24. FUNERAL HOME, ADDRESS Walter Newman & Son, 2161 East Fair Avenue St. Louis, Missouri	25. DATE RECD. BY LOCAL REG. AUG 19 1963	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.
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VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Julius R. Brown

Licensed Embalmer No. 5146

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.