NOV 26 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30144

1. PLACE OF DEATH
County Harrison — Registration District No. 334 — File No. 486
Township — Primary Registration District No. 4197 — Registered No.
City Bethany (No. ..., ... St. ... Ward)

2. FULL NAME Josephine Conger
(a) Residence. No. ... St. ... Ward. ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-13-1856

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
71	2	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Alexander
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Bair
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT Wm Finch
(Address) Bethany Mo.

15. FILED Oct 10, 1927 W J Harned REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-20-1927

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1927, to Oct 20, 1927, that I last saw her alive on Oct 20, 1927, and that death occurred, on the date stated above, at 9:20 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Haemorrhage
46 B
8 B
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) Carcinoma Stomach
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED? 44 A
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ... DATE OF ...
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W J Harned, M. D
Oct 20, 1927 (Address) Bethany

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Miriam Cemetery — DATE OF BURIAL: 10-22 1927

20. UNDERTAKER: S. M. Haas — ADDRESS: Bethany Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Harrison — Registration District No.: 334 — File No.: 406
Township: — Primary Registration District No.: 4197 — Registered No.:
City: Bethany (No. ..., St. ..., Ward)

2. FULL NAME: Josephine Conger

(a) Residence. No. ... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER X Bair
11. BIRTHPLACE OF FATHER (CITY OR TOWN) X
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 1-10 19 28 W J Hamed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 20 1927

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY)
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every i... CAUSE OF DE...

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES U... ES. BEF BY LAW

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