

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.

OCT 31 1930

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

Do not use this space. 160
30763

PLACE OF DEATH

County Phelps Registration District No. 678
Township St James Primary Registration District No. 590X
City Soldiers Home (No. _____) St. _____ Ward _____

2. FULL NAME

William Conley
(a) Residence. No. Soldiers Home St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Iola G Conley
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-11-1847
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 4 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work member soldiers home
(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) Tennessee

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

14. INFORMANT (Address) O. V. Hall
St James Mo.

15. FILED 9-25-1930 Henry F. Walker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/25/1930
17. I HEREBY CERTIFY, That I attended deceased from June 1932 to 9/25/1930 that I last saw him alive on Sept 24/30, and that death occurred, on the date stated above, at 4-00 a.m.

131 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic interstitial Nephritis
(duration) 3 yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) William T. Bailey, M. D.
9/25/1930 (Address) St James Mo

*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 Ironton Cemetery DATE OF BURIAL Sept 26-1930

20. UNDERTAKER Jonas and Newbyck ADDRESS St. James Mo

10

11