

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

Do not use this space.

36175

1. PLACE OF DEATH

County Jackson
Township Waver
City Keokuk (No. General Hospital #2)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1581
St. _____ Ward _____

2. FULL NAME

Conner Mattie
(a) Residence. No. 3417 Hardesleg St., 14 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Use the word) <u>married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF John Conner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 1885

7. AGE <u>45</u>	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Not known.

11. BIRTHPLACE OF (FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Anderson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Anderson
(STATE OR COUNTRY)

14. INFORMANT Wend Clark
(Address) General Hosp #2

15. FILED 11/2 30 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/7/30 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 6, 1930
that I last saw h. 7 PM on Nov. 6, 1930, and that death occurred, on the date stated above, at 11/7/30 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis Chronic

CONTRIBUTORY (SECONDARY) Chronic Interst. Nephritis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED At home

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) D.M. Miller M. D.

11/8 1930 (Address) Hospital #2

*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 Blue Ridge Lawn Cem **DATE OF BURIAL** 11/13 1930

20. UNDERTAKER West. Metropolitan **ADDRESS** 1600 E. 19th

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.

