

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

Do not use this space.

24980

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No. **7303**  
 City Southwest Missouri (No. 100 Route 100 City Hospital # 2 St. .... Ward)

**2. FULL NAME** Williams Albert (Con Way) Conway  
 (a) Residence. No. 2726 Adams St. 22 Ward. (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** M      **4. COLOR OR RACE** Col      **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married  
(write the word)

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**  
1 **OZIE CONWAY**

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** 11-7-1883

**7. AGE**      YEARS      MONTHS      DAYS      IF LESS than 1 day,    hrs. or    min.  
49      8      24

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

**9. BIRTHPLACE (CITY OR TOWN)** RIENZI, MISS.  
 (STATE OR COUNTRY)

**10. NAME OF FATHER** Albert Conway

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** RIENZI  
 (STATE OR COUNTRY) MISS.

**12. MAIDEN NAME OF MOTHER** MARY Stoval

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** RIENZI  
 (STATE OR COUNTRY) MISS.

**14. INFORMANT** OZIE CONWAY  
 (Address) 2726 Adams

**15. FILED** AUG - 8 - 1932 W.A.P. [Signature]  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** July 31 1932

**17. No Physician in attendance. 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 ..... 4:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Gunshot wound of neck  
173 (duration) yrs. mos. ds.

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

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH: 73

**DID AN OPERATION PRECEDE DEATH?** 5 DATE OF

**WAS THERE AN AUTOPSY?** Yes

**WHAT TEST CONFIRMED DIAGNOSIS?**  
 (Signed) Wm. D. [Signature]  
 , IB (Address) Conway

\*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** Father District **DATE OF BURIAL** 8/9 1932

**20. UNDERTAKER** W. C. Boyd **ADDRESS** 4209 1/2 Easton

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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**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.....  
Township.....  
City..... (No.....)

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 7303  
St..... Ward.....

**2. FULL NAME**

William Albert Conway

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 7 - 1883

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>X</u>	<u>48</u>	<u>X</u>	<u>8</u>	<u>24</u>

7. OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....  
10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

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

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19.....

19. UNDERTAKER (ADDRESS)

20. FILED

W. C. Estabrook  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 31, 1932

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

I last saw him..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

..... Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

WRITE PLAINLY WITH INK AND IN CAPITAL LETTERS. THIS IS A PERMANENT RECORD. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

**SUPPLEMENTARY**

24980