

APR 18 1939

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

10640
Do not use this space.

1. PLACE OF DEATH
 (a) County Dallas Registration District No. 241
 (b) Township N. Benton Primary Registration District No. 5334 Registered No. 1213
 (c) City Buffalo (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John K. McConnel
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 Marj McConnel

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July-26-1891

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day,hrs. ormin.
	<u>47</u>	<u>7</u>	<u>17</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as saw mill, bank, etc. Railroad

10. Date deceased last worked at this occupation (month and year) Oct 11 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Co Mo

FATHER

13. NAME John K. McConnel

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nashville Tenn

MOTHER

15. MAIDEN NAME Martha C. Touch

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Co Mo

17. INFORMANT (NAME) James S. McConnel (ADDRESS) Buffalo Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Pittsburg Mo DATE 3-16-39

19. FUNERAL DIRECTOR (NAME) E. K. Smith (ADDRESS) Pittsburg Mo

20. FILED 3/14 1939 Nancy Moran Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-13-39

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h..... 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:
Arterial Sclerosis
 Date of onset _____

Other contributory causes of importance: 97

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) L. Starnes _____
 (Address) Buffalo 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.

RECEIVED

District Health Officer No. 7,

District File Number 7-39-620

Date Filed 4-15-39

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

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.