

1933 JUN 8 1939

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

17755
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township New Primary Registration District No. 1002
 or Mo
 (c) City Mo (d) Street No. General Hospital Registered No. 2157 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 W. O. Thomas Conner
 (a) Residence, No. 514 1/2 Main 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 Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) no Record
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70?
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 9. Industry or business in which work was done, as 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) no Record
 FATHER 13. NAME no unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 MOTHER 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no
 17. INFORMANT Records Clerk
 (ADDRESS) General Hospital
 18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE 5/25 1939
 19. FUNERAL DIRECTOR (NAME) Trisk & Yehin Co
 (ADDRESS) N. E. Mo
 20. FILED May 24, 1939 W. O. Conner
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-6-39 1939
 22. HEREBY CERTIFY That I attended deceased from _____ to _____, 19____
 I _____ on _____, 19____. Death is said to have occurred on the date stated above, at _____
 The principal cause of death and related causes of importance were as follows:
Dying to Red Pneumonic cerebral hemorrhage
 Date of onset _____
 Other contributory causes of importance: 195
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no
 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? no not known (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 no not known
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) W. O. Conner M. D.
 (Address) General Hospital; N. E. 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.

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.