

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.

W. C. [unclear] JUN 24 1939

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

19638
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Francois Registration District No. 775
 (b) Township Ferry Primary Registration District No. 6070-A Registered No. 40
 (c) City Donnardsville (d) Street No. Donnardsville Hospital 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 William Justus Conway
 (a) Residence, No. Donnardsville Mo 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 Roberta Patrick Conway

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 3, 1876

7. AGE YEARS 62 MONTHS 10 DAYS 16 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Auditor
 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 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Francois Co. Missouri

FATHER 13. NAME Joseph Conway
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Lucinda Bean
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Co. Missouri

17. INFORMANT (ADDRESS) Mrs W. J. Conway Donnardsville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE S. V. Cemetery DATE May 21 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Berham, Ind Co Donnardsville Mo

20. FILED 5-21-39 D. W. Hawkins Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 14, 1939, to May 19, 1939.
 I last saw him alive on May 19, 1939. Death is said to have occurred on the date stated above, at 10:30 a. m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of spleen flexure of colon primary Date of onset (7)
46
 Other contributory causes of importance:
Complete obstruction of large intestine 5/14/39

Name of operation Exploratory laparotomy Date of May 17, 1939
 What test confirmed diagnosis? apoptosis findings 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? _____ (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? No.
 If so, specify _____ (Signed) Daniel Edmund, M. D.
 (Address) Donnardsville, Mo

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,

A. J. Claywell

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

A. J. Claywell

Licensed Embalmer No.....

3706

P. O. Address.....

Some Street

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.