

36981

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 199

1. PLACE OF DEATH:

(a) County Randolph **REC'D NOV 20 1939**
(b) City or town Moberly, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Woodland Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
(Specify whether _____)
In this community _____
years, months or days 5 1/2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Monroe
(c) City or town Paris
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) _____
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13
year 1939 hour 3 minute 15 P.M.
21. I hereby certify that I attended the deceased from Oct. 5, 1939, to Oct. 13, 1939;
that I last saw her alive on Oct 13, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pneumonia
Acute suppurative appendicitis with
peritonitis
Due to _____
Other conditions Oct. 10 - Lobar pneumonia
(include pregnancy within 3 months of death)

Duration
Oct 2
1939

Major findings: Suppurative appendicitis
with peritonitis
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature R. De Streeton (M. D. or other) M.D.
Address Moberly, Mo Date signed Oct 16/39

3. (a) PRINT FULL NAME IRMA DORIS CONLEY

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUG 7 1933
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 2 7 hr. min.

9. Birthplace Paris, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Leon D. Conley
13. Birthplace Monroe County, Mo.
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Cecile Seabert
15. Birthplace Monroe Co.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Leon D. Conley
(b) Address Paris, Mo.

17. (a) Burial (b) Date thereof Oct 16, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Near Paris

18. (a) Signature of funeral director Speed H. Blakey
(b) Address Paris, Mo.

19. (a) Oct. 14 - 1939 (b) Leon Williams
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED

District Health Officer No. 10

District File Number 11-39-1945

Date Filed NOV 15 1939

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 *E. H. Agnew*

Licensed Embalmer No. 4000

P. O. Address. *Paris, Mo.*

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.