

DEC 25 1939

Registration District No. **417**

Primary Registration District No. **3021**

Registrar's No. **109**

1. PLACE OF DEATH:  
(a) County Jasper **3**  
(b) City or town Wells City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
408 W. Austin Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community one week years, months or days)

3. (a) PRINT FULL NAME Della Frances Conway **507**  
3. (b) If veteran, name war \_\_\_\_\_ X 3. (c) Social Security No. \_\_\_\_\_ X

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased: May 29 1887  
(Month) (Day) (Year)

8. AGE: Years 52 Months 6 Days 1 If less than one day X hr. X min.

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

10. Usual occupation at Home

11. Industry or business \_\_\_\_\_ X

12. Name J. R. Sparks **1**

13. Birthplace Georgia **0**  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Ann Lines

15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. R. Sparks  
(b) Address 408 W. Austin St.

17. (a) Removal (b) Date thereof Dec 1 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Texas

18. (a) Signature of funeral director Hedge Nelson  
(b) Address Wells City Mo

19. (a) DEC 1 39 (b) G. L. Chicklett M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County WAYNE  
(c) City or town LEEPEY  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6 miles from City R.R. W.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30  
year 1939 hour 9:45 minute A. M.

21. I hereby certify that I attended the deceased from Nov 26  
1939 to Nov 30 1939;  
that I last saw her alive on Nov 30 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to \_\_\_\_\_  
Due to 7/21

Other conditions Chronic Nephritis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations No operation  
Of autopsy No autopsy

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

While at work? \_\_\_\_\_ X (Specify type of place)  
(e) Means of injury \_\_\_\_\_ X

23. Signature G. F. Green (M. D. or other) **DO**  
Address Wells City Mo Date signed 11/30

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. 6,

District File Number 1239-2424

Date Filed DEC 5 1939

**UN 51312**

**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.....

E. M. Hedge....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. 24859

P. O. Address West City

**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.**