

Registration District No. 761

Primary Registration District No. 5624

Registrar's No. _____

FILED JUL 15 1940

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Livingston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether _____)

In this community Life
years, months or days

8. (a) PRINT FULL NAME Grace Gill Connor 560

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Fe

5. Color or race W.

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Martin Connor

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased Sept. 21 1961
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 13 If less than one day hr. _____ min. _____

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

10. Usual occupation at home

MOTHER FATHER

12. Name William Gill

13. Birthplace London England
(City, town, or county) (State or foreign country)

14. Maiden name Mary Anne Coffey

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

16. (a) Informant's own signature Grace Connor

(b) Address Livingston, Mo

17. (a) Burial (b) Date thereof June 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Livingston, Mo

18. (a) Signature of funeral director Winkles

(b) Address Livingston, Mo

19. (a) June 6 (b) Theresa Bates
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 1 mi. S.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4 year 1940 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from Jan, 1935, to June 3, 1940, that I last saw her alive on June 3, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Due to: Chronic venous

Due to: Chronic Cholecystitis

Other conditions: 10 yrs
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Duration _____

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? no

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address Livingston Mo Date signed 6/28/40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should st

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-8-40

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 *Garrest J. Kempe*

Licensed Embalmer No. *32757*

P. O. Address *Livingston, Va.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22118

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 461

Primary Registration District No. 2625

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lebanon, T.P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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.

3. (a) PRINT FULL NAME Grace Nell Connor

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month June day 4
year _____ hour _____ minute _____ M.

4. Sex ♀

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Sept 21 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw h. _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years 78 Months 8 Days 13
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____

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

Major findings: _____

Of operations _____

Of autopsy _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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) _____ Means of injury _____

19. (a) June 6 (b) Delia Bates
(Date received local registrar) (Registrar's signature)

23. Signature C. T. Roland (M. D. or other) _____
Address Lebanon Mo. Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

