

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22511**
Registrar's No. **218**

Registration District No. **668**

Primary Registration District No. **3032**

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

1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bothwell Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pettis
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. RFD #3 Lamonte Missouri
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

8. (a) PRINT FULL NAME Robert Conway
8. (b) If veteran, name war. No. 8. (c) Social Security No. 500

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 25
year 1940 hour 1 minute P M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
8. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

21. I hereby certify that I attended the deceased from June 18th, 1940 to June 25, 1940
that I last saw him alive on June 25, 1940
and that death occurred on the date and hour stated above.

7. Birth date of deceased: February 14 1898
(Month) (Day) (Year)
8. AGE: Years 42 Months 4 Days 11 If less than one day hr. min.

Immediate cause of death Peritonitis
Perforation of Ileum
Due to

Duration
7 days
7 days

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

Due to Kick by mule on June 17 1940 - 7 PM

10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

Major findings: Of operations None

MOTHER FATHER { 12. Name James F. Conway
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mary Crockett
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

Physician 183
Underline the cause to which death should be charged and changed, if any.
Peritonitis and Perforation confirmed by autopsy.

16. (a) Informant Thomas Conway
(b) Address Lamonte Mo. Route # 3.

22. If death was due to external causes in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence His home
(c) Where did injury occur? His home
(City or town) (County) (State)

17. (a) Burial (b) Date thereof June 27/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Salt Fork

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
90% On the farm
While at work? Yes (Specify type of place) (e) Means of injury As stated

18. (a) Signature of funeral director Gillespie Funeral Home
(b) Address Sedalia, Mo.

23. Signature Justs. Oarline M.D. (M. D. or other)
Address Sedalia Mo. Date signed 6-27-40

19. (a) 6-27-40 (Date received local registrar)
Mrs. Harry Sneed (Registrar's signature)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 7-11-40

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 L. E. Bouletier
Licensed Embalmer No. 3867
P. O. Address Madison, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 225-11

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Scalvin
(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 _____
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 Robert Conway

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased Feb 14 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 7 4 11 _____ hr. _____ min.

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)

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 _____

19. (a) 8-14-1940 (b) Mrs. Harry Sneed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
year 1940 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration

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) (c) Means of injury _____

23. Signature Geo. B. Corliss (M. D. or other) _____

Address Scalvin Date signed _____

SUPPLEMENTAL

