

No. 2
17-39
X21492

FILED JUL 15 1940

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 718

Primary Registration District No. 6430

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Putnam
(b) City or town Unionville
(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) 2
(d) Length of stay: In hospital or institution ✓ (Specify whether)
In this community 60 yrs years, months or days

3. (a) PRINT FULL NAME Charles Sigel Conger

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

4. Sex Male
5. Color White
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Betty Conger
6. (c) Age of husband or wife if alive 50 1/2 years

7. Birth date of deceased Aug-8-1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 24
If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Elias Conger

13. Birthplace Cincinnati (City, town, or county) Ohio (State or foreign country)

14. Maiden name Martha Jane Island

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

16. (a) Informant Russ Conger
(b) Address Unionville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Cincinnati Ohio

18. (a) Signature of funeral director W. G. ...
(b) Address Unionville Mo
19. (a) June 4 1940 (Date received local registrar) H. W. Gillum (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Putnam
(c) City or town Unionville
(If outside city or town limit, 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 June day 27th
year 1940 hour 5:00 minute A M.

21. I hereby certify that I attended the deceased from Apr 15, 1940 to June 7, 1940
that I last saw h. a. alive on May 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma - Stomach
Prostate + Rectum

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

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? 645

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature E. A. W. Brown (M. D. or other) _____
Address Warrior, Mo Date signed 6/4/40

Duration _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

46
RECEIVED

District Health Officer No: 10

District File Number: 7-40-1346

Date Filed: JUL 8 1940

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: Murl E. Husted

Licensed Embalmer No. 5504

P. O. Address Unionville, N.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 225-84

Registration District No. 718

Primary Registration District No. 6430

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Putnam
(b) City or town Zimmermanville
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Chas. Sigel Conger
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 24 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2 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 Cerebrovascular accident from high bp. 54 mm hg systolic 34 mm hg diastolic

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

Major findings: Of operations _____

Of autopsy _____

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 E. T. W. Brown (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

