

1. PLACE OF DEATH:

(a) County Franklin Shelton Twp
(b) City or town Edina, R.F.D.
(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 Mo. (b) County Franklin
(c) City or town Edina, R.F.D.
(If outside city or town limits, write "RURAL")
(d) Street No. Shelton Twp.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME GEORGE PEARL CONKLE 524

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

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

6. (b) Name of husband or wife Ruth Conkle 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Nov 17 1889
(Month) (Day) (Year)

8. AGE: Years 50 Months 8 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Geo. J. Conkle

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

14. Maiden name Rosa Willies

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

16. (a) Informant Mrs Ruth Conkle

(b) Address Edina, Mo.

17. (a) Burial (b) Date thereof July 22/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brushier Cemetery

18. (a) Signature of funeral director F.R. Emley

(b) Address Brushier, Mo.

19. (a) July 22 1940 (b) Mrs C.M. Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from 9 am 1940
_____ 19____ to July 20, 1940
that I last saw him alive on July 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage - Duration _____

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

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? _____

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

23. Signature H.M. Humphrey (M. D. or other) _____

Address Brushier, Mo. Date signed _____

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

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.....

Foster P. Easley

Licensed Embalmer No.....

1146

P. O. Address.....

Brechean 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.