

FIFTH OCT 15 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31290

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 95

## 1. PLACE OF DEATH:

- (a) County Cass
- (b) City or town Carrollton  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: 1 0  
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 51 yrs years, months or days)

3. (a) PRINT FULL NAME Frank M Conover

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

4. Sex M.O 5. Color or race A 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Effie Conover 6. (c) Age of husband or wife if alive \_\_\_\_\_ years
7. Birth date of deceased 1 3 1886  
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Ohio  
(City, town, or county) (State or foreign country)10. Usual occupation Retired

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

12. Name Joseph Conover
13. Birthplace Ohio  
(City, town, or county) (State or foreign country)
14. Maiden name Kathleen Brasler
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Conover  
(b) Address Carrollton, Mo.17. (a) Rural (b) Date thereof 9-3-41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Cape Hill Cem18. (a) Signature of funeral director Walter M. ...(b) Address Carrollton, Mo.19. (a) 9-3-41 (b) Walter M. ...  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Cass
- (c) City or town Carrollton  
(If outside city or town limits, write "RURAL")
- (d) Street No. 507 W. ...  
(If rural, give location)
- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1 year 1941 hour 12:25 minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from Dec 1940 to Sept 1941 that I last saw him alive on Sept 1 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Stomach

Due to Do not know how long the

Due to diverting from never saw him last time

Other conditions: Dr. Oak ...  
(Include pregnancy within 3 months of death)

Major findings: None

Of operations \_\_\_\_\_

Of autopsy None

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) (e) Means of injury \_\_\_\_\_

23. Signature Walter M. ... (M. D. or other) \_\_\_\_\_  
Address Carrollton Mo Date signed 9-3-41

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 10-14-41

**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 myself,  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed R. M. Marshall  
Licensed Embalmer No. 7528-  
P. O. Address Carrollton, 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; fact should be so stated above.**

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Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Carroll  
(b) City or town Carrollton  
(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)

3. (a) PRINT FULL NAME Frank M. Conover

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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased 1-30-1869  
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director J W - M

(b) Address \_\_\_\_\_

19. (a) 9-25-41 (b) Paul Haskins  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day \_\_\_\_\_ year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-31290 1941