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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33890

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3828

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution About 15 min. (Specify whether years, months or days)
In this community About 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2316 Harrison 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ROBERT T CONNER

3. (b) If veteran, name war World War

3. (c) Social Security No. 510-07-5213

4. Sex Male 2

5. Color or race Negro

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Aug. (Month) Unk (Day) 1888 (Year)

8. AGE: Years 53 Months 2 Days Unk If less than one day hr. min.

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

10. Usual occupation Butcher

11. Industry or business Cudahy Packing Co

FATHER
12. Name John Albert Conner
13. Birthplace Brownsville (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Parthenia Roddy
15. Birthplace Augusta (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Hamp Conner (Conner)

(b) Address Augusta Ark.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 14 - 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Augusta Ark.

18. (a) Signature of funeral director West Appleton Jans

(b) Address 1905 Vine St.

19. (a) 10/14/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 10-8-41

year hour minute M.

21. I hereby certify that I attended the deceased from 4 45 a. 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 Cerebral hemorrhage

Due to 83 a

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Yes

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Robert Butler (M. D. or other) 3

Address K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 2710

P. O. Address K. C. MO.

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, fact should be so stated above.