

FILED APR 2 1942
Registration District No. **52**

Primary Registration District No. **1001**

1. PLACE OF DEATH:
 (a) County **BUCHANAN**
 (b) City or town **ST. JOSEPH**
 (c) Name of hospital or institution **MERCY HOSP**
 (d) Length of stay: In hospital or institution **1 DAY**
 In this community **1 Day**

3. (a) PRINT FULL NAME **BENJAMIN FRANKLIN CONNER**
 (b) If veteran, name war
 (c) Social Security No. **None**

4. Sex **MALE** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **MARY**
 (b) Name of husband or wife **Jenny Virginia**
 (c) Age of husband or wife if alive **63** years
 7. Birth date of deceased **Sept 28 1872**

8. AGE: Years **69** Months **5** Days **14**
 If less than one day hr. min.

9. Birthplace **CALLAWAY Co. MO.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business

MOTHER FATHER
 12. Name **JAMES SAMUEL CONNER**
 13. Birthplace **VIRGINIA**
 14. Maiden name **KATIE GILMORE**
 15. Birthplace **CALLAWAY Co. MO.**

16. (a) Informant **Joseph Conner**
 (b) Address **Amity Mo.**

17. (a) **Removal** Date thereof **3 12 42**
 (b) Place: burial or cremation **Stewartville**

18. (a) Signature of funeral director **F. J. Brown**
 (b) Address **Stewartville Mo.**

19. (a) **March 12, 1942** (Date received local registrar)
H. J. Mathews (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **DEKALB**
 (c) City or town **AMITY**
 (d) Street No. **RURAL**
 (e) If foreign born, how long in U. S. A. **1** years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **3** day **12**
 year **1942** hour **1:12** minute **P.** M.

21. I hereby certify that I attended the deceased from **3-12-42**
 that I last saw him alive on **3-12-42**
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Acute Cardiac dilatation
Fracture of 10th & 11th ribs on left side
 Due to **Chronic bronchitis**

Due to **Senility**
 Other conditions **Fell 3-9-42 received 2 fractured ribs**
 (include pregnancy within 3 months of death)

Major findings:
 Of operations **ribs**
 Of autopsy **✓**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **Accident**
 (b) Date of occurrence **Mar. 9, 1942**
 (c) Where did injury occur? **DEKALB MISSOURI**
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
HOME

While at work? **✓** (Specify type of place)
 Means of injury **FALL**

23. Signature **W. J. Brown** (M. D. or other) **D.O.**
 Address **823 Farson Stewartville Mo** Date signed **3/12/42**

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

11
1
7

032
0

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *J. G. Lloyd*.....

Licensed Embalmer No. *952*.....

P. O. Address *Stewartville, 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.