

S. S. 42
DM-5-42
ev. 5-17-39
X322873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6975

FILED MAR 6 1944

State File No. _____
Registrar's No. 27-

Registration District No. _____

Primary Registration District No. 3017

1. PLACE OF DEATH:

(a) County Cooper

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

(c) Name of hospital or institution:
St. Vincent's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months
(Specify whether)

In this community 94 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County Cooper

(c) City or town Boonville Lamonte
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Jake McConely

3. (b) If veteran, name war _____

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1944 hour 4 pm minute _____ M.

21. I hereby certify that I attended the deceased from Dec. 1944
19 _____ to Feb 3 19 44
that I last saw h. alive on Feb 3 19 44
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or face white

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

6. (b) Name of husband or wife Jake McConely

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

7. Birth date of deceased June 2 1851
(Month) (Day) (Year)

Immediate cause of death:
Meningitis caused by carcinoma of skull.

Due to _____

Due to _____

8. AGE:	Years	Months	Days	If less than one day
	<u>92</u>	<u>8</u>	<u>I</u>	hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) 13

Major findings: Of operations See above

Of autopsy None made

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

10. Usual occupation Housewife

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 0

11. Industry or business _____

12. Name Elon Ewers

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

14. Maiden name Don't Know

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

16. (a) Informant 2. J. McConely

(b) Address La Monte, Mo

23. Signature Chas. Swap (M. D. or other) MD
Address Boonville, Mo Date signed 2-5-44

17. (a) Burial (b) Date thereof 2-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation North Nashville

18. (a) Signature of funeral director J. F. Owen

(b) Address La Monte, Mo

19. (a) Feb-8-44 (b) Dr. Chas. Swap
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

27
1
2

Duration

8 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
DEPT. OF HEALTH
BUREAU OF HEALTH
DEPT. NO. 3,
FILED
3-3-44

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..... *B. J. Parker*

Licensed Embalmer No. *1542*

P. O. Address *La Monte, 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.

Registration District No. 82

Primary Registration District No. 3013

Registrar's No. 27

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

1. PLACE OF DEATH:
 (a) County Cooper
 (b) City or town Boonville
(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 Cora Alfredda McConely
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 2 1885
(Month) (Day) (Year)

8. AGE: Years 92 Months _____ Days _____
If less than one day, _____ min.

9. Birthplace Ohio
(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 Ledwys McConely

(b) Address Ld Monte, Mo

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb day _____
 year 1949 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 _____

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?

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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

Duration _____
PHYSICIAN

 Underline the cause to which death should be charged statistically.

