

FILED MAR 14 1944

Registration District No. 335

Primary Registration District No. 4492

Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Oran
(c) Name of hospital or institution: 1
(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 Joseph D. O'Connor
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex M Color or race W
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 1 1862
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 16
If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer + Public office

11. Industry or business
12. Name Edmund O. Connor
13. Birthplace Atlanta Ga
14. Maiden name Sarah Gertrude
15. Birthplace Atlanta Ga

16. (a) Informant Otis Bryan
(b) Address Oran Mo
17. (a) Burial (b) Date thereof 2-20-1944
(c) Place: burial or cremation Morley Mo

18. (a) Signature of funeral director _____
(b) Address Oran Mo
19. (a) 3-2-1944 (b) J. E. Lehman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Oran
(d) Street No. _____
(e) Citizen of foreign country? _____
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 2 day 17
year 1944 hour 3 minute 30 M.
21. I hereby certify that I attended the deceased from 2/13 1944 to 2/17 1944
that I last saw him alive on 2/17 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis
Due to _____
Due to _____
Other conditions _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____
23. Signature J. A. Clinch (M. D. or other) _____
Address Oran Mo Date signed 2/17/44

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

RECEIVED

District Health Office No. 2,

District File Number 344-41P

Date 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.....

Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed Hunter Abbitto

Licensed Embalmer No. 4210

P. O. Address Sixston

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.