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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14629

FILED MAY 11 1944  
Registration District No. 120

Primary Registration District No. 4197

Registrar's No. 52

38  
3  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene  
 (b) City or town Stoughton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: W. Alonch Ave.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. 55 Days. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Greene  
 (c) City or town Stoughton  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 71 Alonch Ave  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country NO

3. (a) PRINT FULL NAME Mr. Jacob A. Carley  
 (b) If veteran, name war: \_\_\_\_\_  
 (c) Social Security No. 491-22-7382

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 18 year 1944 hour 7 minute 10 P. M.  
 21. I hereby certify that I attended the deceased from out 20 1944 to Mar 18 1944  
 that I last saw him alive on Mar 10 1944  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W.  
 6. (a) Name of husband or wife: Mrs. Eda S. Conley  
 (b) Name of husband or wife if divorced: Married  
 (c) Age of husband or wife if alive: 43 years  
 7. Birth date of deceased: Mar 21 8 1896  
 (Month) (Day) (Year)

Immediate cause of death Carcinoma of Prostate  
 Due to Secondary Hemorrhage  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) 51R

8. AGE: Years 68 Months 1 Days 10  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Greene Co MO  
 (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: Store

MOTHER FATHER  
 12. Name: Wm. F. Conley  
 13. Birthplace: W. Va  
 (City, town, or county) (State or foreign country)  
 14. Maiden name: Julia A. Maxley  
 15. Birthplace: W. Va  
 (City, town, or county) (State or foreign country)

16. (a) Informant: John Carley  
 (b) Address: Stoughton MO  
 17. (a) Burial (b) Date thereof: 4/20/44  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial Stoughton MO

18. (a) Signature of funeral director: Walter V. Philleas  
 (b) Address: Stoughton MO  
 19. (a) 4/28/44 (b) Wm. H. Webster  
 (Date received local registrar) (Registrar's signature)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: L  
 (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: W. H. Boyles (M. D. or other)  
 Address: Manlyville MO Date signed: 4/20/44

4/22/44 1108 (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 \_\_\_\_\_

*Leroy A. Phillips*

Licensed Embalmer No. \_\_\_\_\_

*1898*

P. O. Address \_\_\_\_\_

*Staten Island, N.Y.*

**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.**