S. No. 2
M—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 28 1944

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

Dr. Lemmon 14659

State File No. 314

Registrar's No. 314

1. PLACE OF DEATH:

(a) County: Greene

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

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

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

In this community: 25 Years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 39

(c) City or town: Springfield (If outside city or town limits, write "RURAL") 2

(d) Street No.: 723 S. Market (If rural, give location) 6

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

If yes, name country:

3. (a) PRINT FULL NAME: Herbert L. Connell

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Anna Connell

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

7. Birth date of deceased: August (Month) 29, (Day) 1865 (Year)

8. AGE: Years 78 Months 7 Days 8 If less than one day hr. min.

9. Birthplace: Lexington (City, town, or county) Indiana (State or foreign country)

10. Usual occupation: Retired

11. Industry or business: Queen City Flour & Feed Co.

FATHER 12. Name: Niram H. Connell

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

MOTHER 14. Maiden name: Jane Sisson

MOTHER 15. Birthplace: Unk. (City, town, or county) Ohio (State or foreign country)

16. (a) Informant: Mrs. Chas. Thompson

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 9, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn

18. (a) Signature of funeral director: H. H. Lohmeyer

(b) Address: Springfield, Mo.

19. (a) 4-7-44 (Date received local registrar) (b) Dr W E Hamby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1944 hour 1 minute 50 a.m.

21. I hereby certify that I attended the deceased from 10/28/43, 19..., to 4/7/44, 19...; that I last saw him alive on 4/6/44, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Eczema, generalized	3 mo
Due to: Diabetes	?
Due to:	
Other conditions: Senility (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

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: J. B. Lemmon (M. D. or other) M.D.

Address: Springfield, Mo. Date signed 4/7/44

98c (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 H. L. McCann

Licensed Embalmer No. 2777

P. O. Address Springfield Me

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.