

No. 2
5-4
5-17-39
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FILED OCT 17 1944

Registration District No. 27

Primary Registration District No. 5834

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Newton

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

(c) Name of hospital or institution home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community 10
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73

(c) City or town Diamond, Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. Marion Township. 0
(If rural, give location)

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

3. (a) PRINTED FULL NAME Tronay Elizabeth Conway

3. (b) If veteran, name war _____

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 5
year 1944 hour 10 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 5-20 1944 to 9-5- 1944
that I last saw her alive on 9-5- 1944
and that death occurred on the date and hour stated above.

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Charles C Conway 6. (c) Age of husband or wife if alive 6-10-72 years
(Month) (Day) (Year)

7. Birth date of deceased 6-10-1876
(Month) (Day) (Year)

Immediate cause of death Acute dilatation of the heart Duration _____

Due to Acute nephritis 3 mos

Due to _____

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

8. AGE: Years 68 Months 2 Days 26 If less than one day hr. _____ min. _____

9. Birthplace Berry County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Tom Hadley

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

14. Maiden name Martha Stipp

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

16. (a) Informant C. C. Conway

(b) Address Diamond, Mo.

17. (a) Burial (b) Date thereof 9-5-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Herona, Mo.

18. (a) Signature of funeral director W. H. Miller

(b) Address Herona, Mo.

19. (a) 9-5-44 (b) Mrs. V. S. Chapman
(Date received local registrar) (Registrar's signature)

Major findings: Of operations none

Of autopsy none

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? _____

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

23. Signature G. C. De Bolt (M. D. or other) _____
Address Diamond, Mo. Date signed 9/6/44

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

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RECEIVED OCT 13 1944

District Health Officer No. _____

District File Number 944-201

Date Filed OCT 13 1944

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 _____

Licensed Embalmer No. 2689

P. O. Address Needs this

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. 244

Primary Registration District No. 5834

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Diamond Mason
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

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 _____

3. (a) PRINT FULL NAME Fronoy Elizabeth Conway

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEP Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 10 1891
(Month) (Day) (Year)

Immediate cause of death acute dilatation of the heart

Due to acute nephritis 3 mos

Due to chr. general nephritis 1 yr?

8. AGE: Years 68 Months 2 Days _____ If less than one day _____ min.

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

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

Major findings: _____

Of operations _____

Of autopsy _____

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)

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? _____

16. (a) Informant _____ (b) Address _____

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)

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

23. Signature G. Cole Bolt M.D. (M. D. or other) _____
Address Diamond MO Date signed 10/1/44

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

SUPPLEMENTAL

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

34901