

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED JAN 19 1945
 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. _____

Registration District No. 381 Primary Registration District No. 4512

1. PLACE OF DEATH:
 (a) County Sullivan
 (b) City or town Milan
 (c) Name of hospital or institution: Simpson Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 36 hrs
 In this community 59 years
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Sullivan
 (c) City or town Milan Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ALBERT J. CONNELL
 (b) If veteran, name war ww
 (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 12 day 9
 year 1944 hour 4 minute 40 a.m.
 21. I hereby certify that I attended the deceased from Dec. 7
1944 to Dec 9 1944
 that I last saw him alive on Dec 9 1944
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced, Married
 6. (b) Name of husband or wife Claudia Lynch
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: 5 (Month) 23 (Day) 1885 (Year)

Immediate cause of death: Tuberculosis R. Lung 2 yrs.
 Duration

8. AGE: Years 59 Months 6 Days 16
 If less than one day hr. _____ min. _____

Due to _____
 Due to _____

9. Birthplace Milan (Rural) 1120 11
 (City, town, or county) (State or foreign country)

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

10. Usual occupation Farmer

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name James Connell

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

14. Maiden name Mary A. Deering

15. Birthplace Sullivan Co Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant Claudia Connell

(b) Address Milan Mo

17. (a) burial (b) Date thereof 12-11-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shatto Cem.

18. (a) Signature of funeral director Scherm Fund Inc.

(b) Address Milan Mo

19. (a) Jan 3 45 (b) Mrs. L. D. Green
 (Date received local registrar) (Registrar's signature)

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 _____
 23. Signature [Signature] (M. D. or other) 100
 Address Milan Date signed 12-9-44

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

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number ~~1-30-210~~

Date Filed ~~JAN-17-1945~~

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed *Dwight Schewe*

Licensed Embalmer No. *2667*

P. O. Address *Milan 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.