

FILED MAR 7 1945

Registration District No. _____

Primary Registration District No. 3025

Registrar's No. 20

1. PLACE OF DEATH:

(a) County West Plains
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Hawley
(c) City or town West Plains 46
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wm Albert Conway

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife Isla Conway 6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased July 1st 1896
(Month) (Day) (Year)

8. AGE: Years 48 Months 6 Days 25 If less than one day hr. min.

9. Birthplace Dent Co., Mo.
(City, town, & county) (State or foreign country)

10. Usual occupation Law mill operator

11. Industry or business _____

12. Name Thos J. Conway

13. Birthplace Dent Co., Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Isla Buice

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

16. (a) Informant Mrs W. A. Conway

(b) Address West Plains, Mo

17. (a) B (b) Date thereof 12-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cremation, Mo

18. (a) Signature of funeral director Robertson

(b) Address West Plains, Mo

19. (a) 2-18-45 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26
year 1945 hour 12 minute 50 A.M.

21. I hereby certify that I attended the deceased from 1/25, 1945, to 1/26, 1945
that I last saw him alive on 1/26, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death 1st & 2nd degree gasolene Burns
Due to 75% body surface

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

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 1/25/45
(c) Where did injury occur? On (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Duckey trail

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

23. Signature Wm J. Thompson (M. D. or other) MD
Address West Plains, Mo Date signed 1/27/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

46
1

RECEIVED

District Health Officer No. 5

District File Number 345127

Date Filed 3.5.45

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 D. D. Roberts

Licensed Embalmer No. 3432

P. O. Address Washington, 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.