

FILED APR 5 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 1300

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days 53 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 519 Harrison  
(If rural, give location)

(e) Citizen of foreign country Naturalized citizen (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CARL CONDE

3. (b) If veteran, name war NO

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 17  
year 45 hour 11 minute 50 P. M.

21. I hereby certify that I attended the deceased from 11/3/44  
19\_\_\_\_ to 3/17/45 19\_\_\_\_;

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

6. (b) Name of husband or wife Anna 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Jan 191973  
(Month) (Day) (Year)

that I last saw him alive on 3/17/45 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years 72 Months 1 Days 28 If less than one day \_\_\_\_\_  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Arterio-sclerotic heart disease

Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Laborer

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Anthony Conde

13. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

14. Maiden name Josie Marchetti

15. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

16. (a) Informant Rose Conde  
(b) Address 519 Harrison

17. (a) Burial (b) Date thereof 3/21/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt St Marys Cem

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? \_\_\_\_\_

18. (a) Signature of funeral director Sebbeto's  
(b) Address 901 E. 5th

19. (a) 3-21-45 (b) T. E. Brown  
(Data received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Dr. E. H. ... (M. D. or other) \_\_\_\_\_  
Address 1109 Prof Bldg, KA Date signed 3/21/45

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

101

**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 Ray Snow  
Licensed Embalmer No. 2560  
P. O. Address K 6 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.**