

No. 2  
 M-5-43  
 v. 5-17-39  
 I X36671

**FILED** AUG 28 1945  
 Registration District No. **128**

Primary Registration District No. **2000**

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

**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: **Springfield Baptist Hospital**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **4 da.** (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **Glen Olin Conley**  
 3. (b) If veteran, name war **UNK.**  
 3. (c) Social Security No. **UNK.**

4. Sex **Male** 5. Color or race **whk.**  
 6. (a) Single, widowed, married, divorced **married**  
 (b) Name of husband or wife **Pearl May Conley** 6. (c) Age of husband or wife if alive **34** years  
 7. Birth date of deceased **Nov. 2, 1900**  
 (Month) (Day) (Year)

**8. AGE:** Years **44** Months **9** Days **10**  
 If less than one day .hr. min.

**9. Birthplace** **Mr. Home Ark. 1**  
 (City, town, or county) (State or foreign country)

**10. Usual occupation** **Farmer**

**11. Industry or business**  
**12. Name** **J. P. Conley**  
**13. Birthplace** **Mr. Home Ark. 1**  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** **Florence Jordan**  
**15. Birthplace** **Unk. Ark. 1**  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** **Mrs. Pearl Conley**  
 (b) Address **Gasville, Ark.**  
**17. (a) Removal** (b) Date thereof **Aug. 12 - 1945**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**18. (a) Signature of funeral director** **Fred E. Thieme**  
 (b) Address **Springfield, Mo.**  
**19. (a) 8-13-45** (b) **Dr. W. E. Handley**  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Arkansas** (b) County **Boyer 99**  
 (c) City or town **Gasville Rural**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **0** (If rural, give location)  
 (e) Citizen of foreign country? **2** (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Aug** day **12** year **1945** hour **7:00** minute **P.M.**  
**21. I hereby certify that I attended the deceased from** **Aug 8**, 1945, to **Aug 12**, 1945;  
 that I last saw him alive on **Aug 12**, 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumococic Meningitis** Duration **3 days**  
**Following a**  
 Due to **pneumonitis & Empyema** **2 wks**  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

**PHYSICIAN**  
 Major findings: \_\_\_\_\_  
 Of operations **None**  
 Of autopsy \_\_\_\_\_  
 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)  
 (c) Means of injury \_\_\_\_\_  
**23. Signature** **Ray Stalloway** (M. D. or other) **MD**  
 Address **Springfield Mo** Date signed **8/14/45**

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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.....

*Fred C. Pieme*

Licensed Embalmer No.....

*2899*

P. O. Address.....

*Springfield, 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.**