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M-5-43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26201

FILED SEP 10 1946

Registration District No. 11

Primary Registration District No. 4024

Registrar's No. 52

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

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Cassville,
(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 _____
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

(c) City or town Cassville
(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 John William McConnell

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 Stella McConnell

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Feb. 14, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

72 5 18 hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel McConnell

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

14. Maiden name Nancy Hayes

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

16. (a) Informant Ceryl McConnell

(b) Address Brea, Calif.

17. (a) Burial (b) Date thereof 8 4 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Don P. Hayes

(b) Address Cassville, Mo.

19. (a) Aug 15-1946 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2
year 1946 hour 3: minute 10 A. M.

21. I hereby certify that I attended the deceased from August
1945 to July 27, 1946
that I last saw him alive on July 27, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 1 hour

Due to _____

Due to _____

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

Major findings:
Of operations: AKO

Of autopsy _____

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? _____

(Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature Don P. Hayes (M. D. or _____)
Address Cassville, Mo. Date signed 8-5-46

RECEIVED

District Health Officer No. 6,

District File Number 946-932

Date Filed SEP 9 - 1946

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 W. C. Koon

Licensed Embalmer No. 4359

P. O. Address Cassville, 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.