

FILED OCT 24 1946 STANDARD CERTIFICATE OF DEATH

State File No. 34027

Registration District No. 175

Primary Registration District No. 8036

Registrar's No. 109

1. PLACE OF DEATH:

(a) County Larancie
(b) City or town Aurora
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Aurora Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 day (Specify whether
In this community 73 years
years, months or days)

3. (a) PRINT FULL NAME

Maudie McConnell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

John J. McConnell

6. (c) Age of husband or wife if alive 16 years

7. Birth date of deceased

July 14 1872
(Month) (Day) (Year)

8. AGE:

Years 73 Months 7 Days 28
If less than one day hr. _____ min. _____

9. Birthplace

Dade Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation

House wife

11. Industry or business

Home

MOTHER FATHER { 12. Name

Joel T. Sembree

13. Birthplace

Jennere
(City, town, or county) (State or foreign country)

14. Maiden name

Maudie McConnell

15. Birthplace

Mo
(City, town, or county) (State or foreign country)

16. (a) Informant

Edna Christensen

(b) Address

Larancie 2040-

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof Greenfield Cemetery
(Month) (Day) (Year)

(c) Place: burial or cremation

Greenfield Cemetery

18. (a) Signature of funeral director

Sam'l. Senecey

(b) Address

Greenfield, Mo.

19. (a)

10-14-46
(Date received local registrar)

ora McNeill
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dade
(c) City or town Greenfield, Mo
(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 No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17
year 1946 hour 7 minute 50 P. M.

21. I hereby certify that I attended the deceased from Sept 15
1946 to Oct 17 1946
that I last saw her alive on Oct 12 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Ac. Cholecystitis
& rupture of Gall bladder
Duration ?

Due to Diabetes Mellitis 5 yrs

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no operation done

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) no
(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 R. D. Lowan (M. D. or _____)
Address Aurora, Mo Date signed 10/17/46

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

RECEIVED

District Health Officer No. 6,

District File Number 1046-1059

Date Filed OCT 22 1946

2 No. 28
2A-3-2M
X 1

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 Sam E. Seiseney Jr
Licensed Embalmer No. 4099
P. O. Address Greenfield, 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.

Registration District No. *175*

Primary Registration District No. *3036*

Registrar's No. *109*

1. PLACE OF DEATH:

(a) County *Lawrence*
(b) City or town *Aurora*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME *Maudie McConnell*

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

4. Sex *F* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *Wid*

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

7. Birth date of deceased. *July 14*
(Month) (Day) (Year)

8. AGE: Years *73* Months Days If less than one day hr. min.

9. Birthplace. (City, town, or county) (State or foreign country) *Mo*

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director

(b) Address

19. (a) *10-14-46* (Date received local registrar) (b) *Oran Mc Natt* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* Day *14* Year *1946* hour minute M.

21. I hereby certify that I attended the deceased from *July 14* to *July 14*, 19*46*; that I last saw him *alive* on *July 14*, 19*46*; and that death occurred on the date and hour stated above. Immediate cause of death.

Duration

Due to

Due to

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

Major findings: Of operations

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?

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

23. Signature (M. D. or other)

Date signed

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

SUPPLEMENTARY

34027