

FILED JAN 20 1947

Registration District No. _____

Primary Registration District No. **3041**

Registrar's No. **145**

1. PLACE OF DEATH:

(a) County **Macon**
 (b) City or town **macon**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Macon 61**
 (c) City or town **Macon Mo.** **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____ **2**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME **Male J. M. Connell**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **483-12-6615**

4. Sex **Male** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Widower**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Dec. 29 - 1896**
(Month) (Day) (Year)

8. AGE: Years **50** Months **11** Days **24**
If less than one day hr. min.

9. Birthplace **Ringoes Co., Ia**
(City, town, or county) (State or foreign country)

10. Usual occupation **Painter**

11. Industry or business _____

12. Name **George M. Connell**

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

14. Maiden name **Reines**

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

16. (a) Informant **Boyle M. Connell**

(b) Address **Dan West**

17. (a) Burial **Ellipton Iowa** **(b) Date thereof** **12-27-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial _____

18. (a) Signature of funeral director **Stephen J. Gooding**

(b) Address **Macon Mo**

19. (a) 1-16-47 **(b) Ruth M. Neely**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **24**
 year **1946** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Dec 23**, 19**46** to **Dec 24**, 19**46**
 that I last saw him alive on **Dec 23**, 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** **10 hrs**
Duration

Due to _____

Due to _____

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

Major findings: Of operations **94A**

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 **0**

23. Signature **Howard Miller** (M. D. or other)

Address **Macon** Date signed **12/27/46**

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

MAR 3 1947

MAY 5 1947

RECEIVED
District Health Officer No.
State File Number 1-47
Date Filed JAN 18 1947

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

C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.