

FILED MAR 31 1947

Registration District No. 121

Primary Registration District No. 5460

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural Clay Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route # 3 Springfield, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days / (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene ³⁹
(c) City or town Rural Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 3
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clara Conant

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Harold H. Conant 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 3 1893
(Month) (Day) (Year)

8. AGE: Years 53 Months 3 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Hutchinson Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Main

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

14. Maiden name Susanna H. Hardin

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

16. (a) Informant Susanna H. ~~Hotze~~ Hotze
(b) Address Oklahoma City, Okla.

17. (a) Burial (b) Date thereof 3/22/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) Mar. 24 - 47 (b) Mrs. Thaid Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1947 hour About 9 minute A M.

21. I hereby certify that I attended the deceased from
No physician or attendance
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Crushing injury of skull
Duration _____

Due to Blow with a hammer

Due to _____

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

Major findings: 169
Of operations _____

Of autopsy Healed and healed
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) Homicide
(b) Date of occurrence March 19, 1947
(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?

In the home
While at work? _____ (Specify type of place)
(c) Means of injury Hammer

23. Signature James C. Stone (M. D. or other) _____

Address Springfield, Mo. Date signed 3-25-47

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

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9

RECEIVED

Crocker County Health Office,

County File Number 47-3-35

Date Filed 3/28/47

SEP 1 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.

This body not embalmed.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.