

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20536

FILED JUL 14 1947

Registration District No. 120

Primary Registration District No. 5444

State File No.

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Gentry  
(b) City or town Rural Athens Township  
(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 lifetime  
years, months or days)

3. (a) PRINT FULL NAME John Mitchell Mc Conkey

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

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

6. (b) Name of husband or wife Ester Schwader 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased July 15 1883  
(Month) (Day) (Year)

8. AGE: Years 63 Months 10 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Gentry Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name George Mc Conkey

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

14. Maiden name Samanther Lowe

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

16. (a) Informant Mrs. Mitchell Mc Conkey

(b) Address Albany, Mo. R.F.D.

17. (a) Burial (b) Date thereof 6-5-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion

18. (a) Signature of funeral director Robert Burke

(b) Address Albany, Missouri

19. (a) July 1-1947 (b) Home D. Debatas  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry

(c) City or town Rural - Athens  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3  
year 1947 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from June 3 - 1947 to June 3 - 1947  
that I last saw him alive on June 3, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Thrombosis Duration 11 days

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 Frank H. Ross (M. D. or other) MD  
Address Albany, Mo. Date signed 6-3-47

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

MOTHER FATHER

**DISTRICT HEALTH OFFICE**  
**Cameron, Mo.**

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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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Clifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany 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.**