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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. 333827

FILED OCT 1 1947
3 24

Registration District No. 324

Primary Registration District No. 6093

Registrar's No.

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Rural - Marshall, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7 miles north west of Marshall
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether)
In this community all his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 7 miles northwest of Marshall
(If rural, give location) Mo.
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME W. H. Conner

3. (b) If veteran, name war
3. (c) Social Security No. NONE

4. Sex male 5. Color or race wh
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Nancy Belle Conner
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased Sept 2 1874
(Month) (Day) (Year)

8. AGE: Years 73 Months 0 Days 7
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Robert Conner
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Little
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Robert E. Conner

(b) Address Route #1 Malta Bend, Mo

17. (a) Burial (b) Date thereof 9-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Campbell-Lewis
(b) Address Marshall Mo.
19. (a) 9-13-1947 (b) Friday Gray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9th
year 1947 hour 1:00 minute P.M.

21. I hereby certify that I attended the deceased from incl 1947 to Sept 1947
that I last saw him in alive on 9/8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to Ch. Bronchitis 7 yrs

Due to

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 108
Of autopsy

Duration
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 Robert Conner (M. D. or other)
Address Marshall, Mo. Date signed 9-13-47

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

MOTHER FATHER

Junior Health Officer No. 8,

Debit File Number

Date Filed

9-30-47

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. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall ms

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.