S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 20 1947

Registration District No. 42

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 33742

Registrar's No. 1225

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

1. PLACE OF DEATH:
(a) County Buchanan McConne
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Mo. Meth. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 weeks (Specify whether
In this community 1 month
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay 24
(c) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Not stated
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Della B. McConnell
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife C. R. McConnell
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December (Month) 13 (Day) 1880 (Year)

8. AGE:	Years	Months	Days	If less than one day
	66	9	28	hr. min.

9. Birthplace Hamilton County Ohio
(City, town, or county) (State or foreign country)
10. Usual occupation At home
11. Industry or business At home
FATHER
12. Name David Holloway Brant
13. Birthplace Hamilton County Ohio
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Margaret Boggs
15. Birthplace Hamilton County Ohio
(City, town, or county) (State or foreign country)
16. (a) Informant Dr. M. S. Harvey
(b) Address St. Joseph, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/11/47 (Month) (Day) (Year)
(c) Place: burial or cremation Excelsior Springs, Mo.
18. (a) Signature of funeral director Hedton-Bowman
(b) Address St. Joseph, Mo.
19. (a) 10-16-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature) 282

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month october day 11
year 1947 hour 1 minute 15 A.M.
21. I hereby certify that I attended the deceased from Oct 1-1947, 19..., to Oct 11, 1947
that I last saw her alive on Oct 11, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Ca of breast	5 yrs
Metastasis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 50
Of autopsy none 50

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Wm. [illegible] (M. D. or other)
Address 411 Kirkpatrick Bldg St. Joseph, Mo. Date signed 10/16/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

OCT 20 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 Francis J. Wyland Jr., Registered Apprentice No. 444, working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St Joseph, 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.