

FILED MAY 7 1949

STANDARD CERTIFICATE OF DEATH

State File No. 14646

BIRTH NO. _____ REG. DIST. NO. 359 PRIMARY REG. DIST. NO. 4527 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, write RURAL and give township) Bronaugh		c. CITY (If outside corporate limits, write RURAL and give township) Bronaugh	
c. LENGTH OF STAY (In this place) 26 days		d. STREET ADDRESS (If rural, give location) Burch 1 mi west	
d. FULL NAME OF HOSPITAL OR INSTITUTION None		e. mi north	

3. NAME OF DECEASED (Type or Print) a. (First) George Justes b. (Middle) Mc c. (Last) CONN			4. DATE OF DEATH (Month) (Day) (Year) 4-16-49		
5. SEX male		6. COLOR OR RACE Wh.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	
8. DATE OF BIRTH 4-18-87		9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Days 11 IF UNDER 24 Hrs. Hours 28 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) miner (coal)		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Guthrie Co. Iowa U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME No Data		13b. MOTHER'S MAIDEN NAME No Data		14. NAME OF HUSBAND OR WIFE None	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Charles Mc Conn RR Mulberry Kansas	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.		DUE TO (b) Hypertension					
		DUE TO (c)					
						4201	

19a. DATE OF OPERATION 4/16/49		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Bronaugh Vernon Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **4/16, 1949** to **4/16, 1949** that I last saw the deceased alive on **4/16, 1949**, and that death occurred at **9 a. m.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. G. Eddleman M.D.		23b. ADDRESS Liberal Mo		23c. DATE SIGNED 4/25/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4-18-49		24c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery		24d. LOCATION (City, town, or county) (State) Oskafoosa Mo.	
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DATE REC'D BY LOCAL REG. April 27 1949		REGISTRAR'S SIGNATURE Ms Ruth Faith		FUNERAL DIRECTOR'S SIGNATURE Charles A. Dudley		ADDRESS Mulberry Kansas	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 4-89-501

Date Filed 5-5-49

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Phillip Koence

Licensed Embalmer No. 3935

P. O. Address Pittsburg, Kan.

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.