

FILED AUG 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29219**

BIRTH NO. _____ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3874** Registrar's No. **1229**

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston 1003	
c. LENGTH OF STAY (in this place) 6 months		d. STREET ADDRESS (If rural, give location) 411 Ruth st	
d. FULL NAME OF HOSPITAL OR INSTITUTION 111 Ruth			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Mary	b. (Middle) Edna	c. (Last) McConnell	August 6, 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH February 11, 1895		9. AGE (In years last birthday) 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cairo, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Van Armour	13b. MOTHER'S MAIDEN NAME Cora Talbott	14. NAME OF HUSBAND OR WIFE Leon McConnell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 332-03-3895	17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Leon M. McConnell 411 Ruth St
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of cervix		INTERVAL BETWEEN ONSET AND DEATH 1 year
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinomatosis		

19a. DATE OF OPERATION 4-8-51	19b. MAJOR FINDINGS OF OPERATION Biopsy of cervix. Carcinoma	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 **4-8, 1951**, to **7-28, 1951**, that I last saw the deceased alive on **7-28, 1951**, and that death occurred at **8:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Wilson J. Anguison M.D. (Degree or title)	23b. ADDRESS Sikeston, Mo.	23c. DATE SIGNED Aug 6, 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE aug. 8th	24c. NAME OF CEMETERY OR CREMATORY Thistlewood	24d. LOCATION (City, town, or county) (State) Mounds Cabela Illinois
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DATE REC'D BY LOCAL REG. Aug 8-51	REGISTRAR'S SIGNATURE Mrs. Ella Hunter	25. FUNERAL DIRECTOR'S SIGNATURE Frank A. Kasher ADDRESS Cairo Ill
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(Licensed Embalmer's Statement on Reverse Side)

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

1003

RECEIVED

RECEIVED AUG 13 1951

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 851-178

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.

Signed Frank A. Karcher

Signed _____
Student Embalmer

Licensed Embalmer No. 2103

P. O. Address Paris Ill

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.