

FILED MAR 3 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6930

State File No.

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Marshall, Mo</u> c. LENGTH OF STAY (in this place) <u>56 hours</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u> 0971	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>513 Short Street</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>GEORGE</u> b. (Middle) <u>EMMETT</u> c. (Last) <u>McConnell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-22-52</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct-2-1889</u>
9. AGE (In years) (last birthday) <u>62-4-20</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Loganville engineer - 2 months</u>	11. BIRTHPLACE (State or foreign country) <u>Ill</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel V. McConnell</u>	
13b. MOTHER'S MAIDEN NAME <u>Cora Babbree</u>		14. NAME OF HUSBAND OR WIFE <u>Abby McConnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>709-10-9513</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Abby McConnell</u>		ADDRESS <u>Slater</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>x 709-10-9513</u> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>c Thrombocytopenia</u>	
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.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) _____		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 <u>Feb. 20, 1952</u> to <u>Feb. 22, 1952</u> , that I last saw the deceased alive on <u>Feb. 22, 1952</u> , and that death occurred at <u>9:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>J. J. McJannet, Jr.</u> (Degree or title) _____		23b. ADDRESS <u>Slater Mo.</u>	
23c. DATE SIGNED <u>2/23/52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		24b. DATE <u>2-25-52</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Slater City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Slater Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-25-1952</u>		REGISTRAR'S SIGNATURE <u>Sidney T. Gray</u> 3850	
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jones</u>		ADDRESS <u>Slater Mo</u>	

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

James E. Jones

Licensed Embalmer No. _____

3143

P. O. Address _____

Slater M

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.