

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37687**

No. 300
10-48

FILED DEC 15 1952

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1286**

1170

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

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 35 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph 8117		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			d. STREET ADDRESS (If rural, give location) 4627 1/2 King Hill Ave. 3		
3. NAME OF DECEASED (Type or Print) a. (First) VIRGIL		b. (Middle) H	c. (Last) CONARD		4. DATE OF DEATH (Month) (Day) (Year) Dec. 5, 1952
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 12, 1896	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph operator		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Rushville, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Albert M. Conard		13b. MOTHER'S MAIDEN NAME Margaret Gilman		14. NAME OF HUSBAND OR WIFE Mary T. Conard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 712-01-5280		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mary T. Conard 4627 1/2 King Hill	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>This does not mean mode of dying, such as suffocation, asphyxiation, etc. It means the disease, injury, or complication which caused death.</i>			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardiac Decompensation - acute left heart failure			INTERVAL BETWEEN ONSET AND DEATH 4 hrs		
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Myocardial Insufficiency			DUE TO (b) 2 to 4 yrs		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Several previous attacks of Decompensation			DUE TO (c)		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 4222 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) 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 Dec. 2, 1952 , to Dec. 5, 1952 , that I last saw the deceased alive on Dec. 4, 1952 , and that death occurred at 12:05 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) [Signature]			23b. ADDRESS St. Joseph, Mo.		23c. DATE SIGNED 12-6-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 8, 1952		24c. NAME OF CEMETERY OR CREMATORY, LOCATION (City, town, or county) (State) Memorial Park Cem. St. Joseph, Mo.	
DATE REC'D BY LOCAL REG. Dec. 11, 1952		REGISTRAR'S SIGNATURE Carl C. Casty 446		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Dark Funeral Home 120 Illinois Av.	

DEC 17 1952

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..... *E. A. Clark*

Licensed Embalmer No. *47238*

P. O. Address..... *St. Joseph*

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.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State of Missouri
County of Buchanan SS.

State File No. _____
Local Registrar's No. 1286

AFFIDAVIT FOR CORRECTION OF A RECORD

On this 16 day of December, 1952 before me appears _____
Mrs. V. H. Conrad, who, upon her oath, states that the original record of ^{birth} death
for Virgil H. Conrad died Dec 5 ^{born} _____, 1952, in the State of
Missouri, and which was filed at St Joseph on Dec 11, 1952, should be corrected as follows:

Item No. _____ should read _____

Instead of _____

Item No. 8 should read Sept 18, 1896

Instead of _____ Sept 19, 1896

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief

(SEAL)

Affiant Mrs V H Conrad wife
Relationship _____

4627 1/2 King Hill Ave
Present Address.

Subscribed and sworn to before me this 16 day of December, 1952

My Commission expires _____
My Commission Expires Nov. 3, 1956
Louy P. Baker Notary Public.

37687