

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

FILED MAY 18 1953

State File No. **17693**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **460**

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>GREENE</b>  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b><br>b. COUNTY <b>Christian</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>   | c. LENGTH OF STAY (in this place) | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Nixa "RURAL" PORTER</b>                                     | d. STREET ADDRESS (If rural, give location) <b>ROUTE # 1</b> |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>WAZARK OSTEOPATHIC HOSPITAL</b> |                                   | d. STREET ADDRESS (If rural, give location) <b>ROUTE # 1</b>  |  |

|                                     |                       |                         |                            |   |
|-------------------------------------|-----------------------|-------------------------|----------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Joe</b> | b. (Middle) <b>Ross</b> | c. (Last) <b>McConnell</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>May 10, 1953</b> |
|-------------------------------------|-----------------------|-------------------------|----------------------------|---|

|                    |                               |   |                                       |   |                           |                           |                           |                           |
|--------------------|-------------------------------|---|---------------------------------------|---|---------------------------|---------------------------|---------------------------|---------------------------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b> | 8. DATE OF BIRTH <b>March 4, 1929</b> | 9. AGE (In years last birthday) <b>24</b> | 10. UNDER 1 YEAR <b>2</b> | 11. UNDER 1 WEEK <b>6</b> | 12. UNDER 1 HOUR <b>0</b> | 13. UNDER 1 MIN. <b>0</b> |
|--------------------|-------------------------------|---|---------------------------------------|---|---------------------------|---------------------------|---------------------------|---------------------------|

|  |   |  |  |
|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b> | 11. BIRTHPLACE (State or foreign country) <b>Nixa, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
|--|---|--|--|

|  |  |   |
|--|--|---|
| 13. FATHER'S NAME <b>Ross T. McConnell</b> | 13b. MOTHER'S MAIDEN NAME <b>Mynthe Wisner</b> | 14. NAME OF HUSBAND OR WIFE <b>None</b> |
|--|--|---|

|  |  |  |                              |
|--|--|--|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>Unknown</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mynthe McConnell - Nixa, Mo.</b> | 18. ADDRESS <b>Nixa, Mo.</b> |
|--|--|--|------------------------------|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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) <b>pneumonia</b>   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |                                  |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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 **5-6**, 19**53** to **5-10**, 19**53** that I last saw the deceased alive on **5-10**, 19**53** and that death occurred at **5:10 AM** from the causes and on the date stated above.

|   |                               |                                 |
|---|-------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>Harold Shaffer M.D.</b> | 23b. ADDRESS <b>Nixa, Mo.</b> | 23c. DATE SIGNED <b>5-10-53</b> |
|---|-------------------------------|---------------------------------|

|   |                              |  |  |
|---|------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> | 24b. DATE <b>MAY 13 1953</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>PAYNE CEMETERY</b> | 24d. LOCATION (City, town, or county) (State) <b>CHRISTIAN CO., MISSOURI</b> |
|---|------------------------------|--|--|

|   |  |  |                                 |
|---|--|--|---------------------------------|
| DATE REC'D BY LOCAL REG. <b>5-14-53</b> | REGISTRAR'S SIGNATURE <b>Edith Williamson Reg.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>John Dean Harris</b> | ADDRESS <b>Clever, Missouri</b> |
|---|--|--|---------------------------------|

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

**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 John Dean Harris

Licensed Embalmer No. 4390

P. O. Address Cleveland, Mo.

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.