

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26041**

FILED AUG 3 1953

BIRTH NO. **12445715-53** REG. DIST. NO. **316** PRIMARY REG. DIST. NO. **3059** Registrar's No. **262**

1. PLACE OF DEATH a. COUNTY St. Francis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Washington	
b. CITY OR TOWN Bonne Terre	c. LENGTH OF STAY (In this place) 18 mo.	c. CITY OR TOWN Rural Liberty Twp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bonne Terre Hospital		d. STREET ADDRESS (If rural, give location) Near Potosi	

3. NAME OF DECEASED (Type or Print) Clarence Clinton McConnell			4. DATE OF DEATH (Month) (Day) (Year) July 21 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 29, 1953		9. AGE (In years last birthday) 18 Months 18 Days 18 Hours 18 Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (City and State or Foreign Country) Bonne Terre Mo	
13a. FATHER'S NAME Clarence C. McConnell			13b. MOTHER'S NAME Ethel Farrow		14. NAME OF HUSBAND OR WIFE Never Married

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clarence C. McConnell, Potosi, Mo.	
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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 1 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital atelectasis of lungs		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature delivery 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		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 **7/20** 19**53**, to **7/21** 19**53**, that I last saw the deceased alive on **7/21/53**, 19**53**, and that death occurred at **2:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Name of title) Wm. W. Clinton M.D.		23b. ADDRESS 33 N. Allen, Bonne Terre, Mo.		23c. DATE SIGNED 7/27/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-23-53		24c. NAME OF CEMETERY OR CREMATORY Sun Set Hills Cem	
24d. LOCATION (City, town, or county) (State) Washington Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ms. Luther Spack Potosi Mo.		DATE REC'D BY LOCAL REG. July 27, 1953	

(Licensed Embalmer's Statement on Reverse Side)

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 *Murphy L. Spahr* _____

Licensed Embalmer No. *4256* _____

P. O. Address *Flat River, Mo* _____

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.