

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35440**
REG. DIST. NO. **93** PRIMARY REG. DIST. NO. **4154** Registrar's No. **53-90**

FILED OCT 19 1953

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

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greenfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greenfield	
c. LENGTH OF STAY (in this place) 8 years		d. STREET ADDRESS (If rural, give location) 324 Carr Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 324 Carr Street			
3. NAME OF DECEASED (Type or Print) a. (First) Fredrick b. (Middle) Francis c. (Last) Conn		4. DATE OF DEATH (Month) (Day) (Year) Oct. 9, 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 8, 1874
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 0 Days 1	IF UNDER 12 HRS. Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nati Farm Loan, Sec. Tres.		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) Dade Co., Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Romaine R. Conn		13b. MOTHER'S MAIDEN NAME Sarah Jane Harris	14. NAME OF HUSBAND OR WIFE Nettie Belle Conn
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 489-36-6498	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Nettie B. Conn; Greenfield Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastrointestinal Malignancy		INTERVAL BETWEEN ONSET AND DEATH 4 wks	
ANTECEDENT CAUSES		DUE TO (b) _____	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS		DUE TO (d) _____	
Conditions contributing to the death but not related to the disease or condition causing death. Prostatitis		_____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 159X	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 10-7, 1953 , to 10-9, 1953 , that I last saw the deceased alive on 10-7, 1953 , and that death occurred at 9:05 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Lee A. McNeel, M.D.		23b. ADDRESS Greenfield, Mo.	23c. DATE SIGNED 10-13-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 13, 1953	24c. NAME OF CEMETERY OR CREMATORY Greenfield Cem.	24d. LOCATION (City, town, or county) (State) Cedar County, Mo.
DATE REC'D BY LOCAL REG. 10-13-53	REGISTRAR'S SIGNATURE J. C. Canada 478	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. C. Canada, Greenfield, Mo.	

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 J. C. Canada
Licensed Embalmer No. 4196

P. O. Address Greenfield, 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.