

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **37935**  
REGISTRAR'S NUMBER **4913**

FILED NOV 28 1956

Registration District No. **149** Primary Registration District No. **1002**

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>                  |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>Kansas City North 5018</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>             |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Joseph Hospital</b> |  | Length of stay in 1b <b>9 hours</b>   | d. STREET ADDRESS <b>3507 East 54th</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br><b>David B. Conner</b> |  |  | 4. DATE OF DEATH<br><b>Nov 13 1956</b>          |  |  |
| First <b>David</b> Middle <b>B.</b> Last <b>Conner</b>        |  |  | Month <b>Nov</b> Day <b>13</b> Year <b>1956</b> |  |  |

|                       |                                  |  |  |   |  |
|-----------------------|----------------------------------|--|--|---|--|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov 13 1956</b> | 9. AGE (In years last birthday)<br>IF UNDER 1 YEAR: Months <b>9</b> Days <b>10</b><br>IF UNDER 24 HRS: Hours <b>9</b> Min <b>10</b> |  |
|-----------------------|----------------------------------|--|--|---|--|

|  |  |   |  |
|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> | 11. BIRTHPLACE (City and state or country)<br><b>Kansas City Missouri</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
|--|--|---|--|

|  |  |
|--|--|
| 13. FATHER'S NAME<br><b>Eugene B. Conner</b> | 14. MOTHER'S MAIDEN NAME<br><b>Leta Mae Hodges</b> |
|--|--|

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|--|--|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT<br><b>Eugene B. Conner, 3507 E. 54th North</b> |
|--|--|--|

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurely In utero</b><br>DUE TO (b) <b>Premature labor of mother</b><br>DUE TO (c) <b>Concurrent</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Infant 6 1/2</b><br><b>776x</b>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

|   |  |   |
|---|--|---|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |
| 20c. TIME OF INJURY<br>Hour <b>p. m.</b> Month, Day, Year   |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)    | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

|   |  |                                     |
|---|--|-------------------------------------|
| 21. I attended the deceased from <b>Birth</b> to <b>11-13-56</b> and last saw <b>him</b> alive on <b>11-13-56</b><br>Death occurred at <b>Home</b> on the date stated above; and to the best of my knowledge, from the causes stated. |  |                                     |
| 22a. SIGNATURE (Type or print)<br><b>John Haight, M.D.</b>  | 22b. ADDRESS<br><b>3401 E 12th KC Mo</b> | 22c. DATE SIGNED<br><b>11-14-56</b> |

|  |                                |   |  |
|--|--------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>Nov. 15 56</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Hill Cem.</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City Missouri</b> |
| 24. FUNERAL DIRECTOR<br><b>Mellody McGilley Eylar</b>      | ADDRESS<br><b>Kan City Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>11-14-56</b>               | 26. REGISTRAR'S SIGNATURE<br><b>Reva Minshall</b>                            |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service  
300 1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
John Haight, M. D.

MEDICAL CERTIFICATION

Dr Haight  
3401 E 12 st.

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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.....  
Signature of Student Embalmer

Signed..... *James W. Wain*  
Licensed Embalmer No. *463*

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.