

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008883

STATE FILE NUMBER

FILED APR 7 1958

Registration District No.

42

Primary Registration District No.

1000

Registrar's No.

867

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY 1251		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Cameron		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5610 So. 9th. St.		Length of stay in lb 2 mon.	d. STREET ADDRESS Not known		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HALLIE MAY CONAWAY			4. DATE OF DEATH Month Day Year March 31 1958		
5. SEX Female /	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1881	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Stewartsville, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME David Harris		13b. MOTHER'S MAIDEN NAME Caroline Lamb		14. NAME OF HUSBAND OR WIFE None	
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 Mrs. H. L. Bradford 5610 S. 9th. St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) <u>4222F</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture lt. femur - Jan. 6, 1958</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
20a. ACCIDENT <input checked="" 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.) <u>Fall at home</u>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. 1 6 '58 p.m.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Cameron		COUNTY STATE Mo	
21. I attended the deceased from <u>Feb. 1958</u> to <u>Mar. 31, 1958</u> and last saw her alive on <u>Mar. 28, 1958</u> Death occurred at <u>2:00 a m</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ed Grant M.D.</u>		22b. ADDRESS <u>St. Joseph, Mo. 1307 Taron</u>		22c. DATE SIGNED <u>3.31.58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 2, 1958	23c. NAME OF CEMETERY OR CREMATORY Coffey Cem.	23d. LOCATION (City, town, or county) (State) Coffey Mo.		
24. FUNERAL DIRECTOR <u>Clark</u> ADDRESS Clark Funeral Home St. Joseph		25. DATE RECD. BY LOCAL REG. <u>Mar 31, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mar. Clark</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc., may use only when necessary. All diseases in Part I must be causally related.

300
-57

Health,
Welfare
Public
Service

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 *Paul F. Clark*

Licensed Embalmer No. *5024*

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