

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027907  
STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 128

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Morehouse</b> <b>07-20</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Mo. Delta Community INSTITUTION <b>Hospital</b> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>—</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Basil</b> Middle <b>Eugene</b> Last <b>Mc Connell</b>			4. DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>II-29-1930</b>	9. AGE (In years last birthday) <b>27</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painting</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	11. BIRTHPLACE (City and state or country) <b>Morehouse, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13. FATHER'S NAME <b>Athel McConnell</b>	14. MOTHER'S MAIDEN NAME <b>Maggie Reynolds</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) <b>YES KOREAN</b>	16. SOCIAL SECURITY NO. <b>449-307844</b>	17. INFORMANT <b>Mrs. Basil McConnell, Morehouse, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right side heart failure - due to</b> <b>Submassive myocardial infarction - Cause</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Submassive myocardial infarction - Cause</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks -</b> <b>unknown</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? 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 Hour <b>10:40</b> Month <b>July</b> Day <b>5</b> Year <b>1958</b> a. m. <b>P.</b> p. m.		
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 **6 June 57** to **July 5 1958** and last saw her alive on **5 July 58**  
Death occurred at **10:40 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>H.B. Shrago, M.D.</b>	22b. ADDRESS <b>Debeaton, Mo</b>	22c. DATE SIGNED <b>7 July 58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7-7-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BERNIE CITY</b>	23d. LOCATION (City, town, or county) (State) <b>BERNIE MO</b>
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24. FUNERAL DIRECTOR <b>Walter Francis Moore - Sikeston Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-8-58</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Ellen Hunter</b>
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service  
300 1-56  
All 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

MEDICAL CERTIFICATION

DATE RECEIVED

7-14-58

JUL 21 1958

SCOTT CO. HEALTH DEPT.

FILE No.

258-173

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 *Raymond Crews*

Licensed Embalmer No. 340

P. O. Address *Sikeston*

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.