

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037221

STATE FILE NUMBER

FILED NOV 3 1958 Registration District No. 238 Primary Registration District No. 4345 Registrar's No. 31

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1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before (and in) institution) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Matthews</u>		c. CITY OR TOWN <u>Lilbourn</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sells Nursing Home</u>		Length of stay in 1b <u>2wks</u>	
3. NAME OF DECEASED (Type or print) First <u>Jim</u> Middle <u>McConnell</u> Last <u>McConnell</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>About 1868</u>
9. AGE (In years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pensioner</u>	11. BIRTHPLACE (City and state or country) <u>New Madrid Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Tom McConnell</u>	
13b. MOTHER'S MAIDEN NAME <u>Mattie Owens</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harry Ritchie-Lilbourn, Mo.</u>		Address	
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>Unknown-Died unattended</u> <u>Died in nursing home.</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
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 _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 <u>Lilbourn, Mo.</u>	
20g. COUNTY		20h. STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>8:00</u> p. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. E. Jones, M.D.</u>		22b. ADDRESS <u>Lilbourn, Mo.</u>	
22c. DATE SIGNED <u>Oct 13, 58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-7-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Near Lilbourn, Mo.</u>
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-20-58</u>	26. REGISTRAR'S SIGNATURE <u>Fay Hedgereth</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DATE RECEIVED OCT 21 1958
NEW MADRID CO. HEALTH CENTER
A. J. S.

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 Harold H. Ponder

Licensed Embalmer No. 5930

P. O. Address Lilbourn, 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.