Health, & Welfare Public Service

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FILED DEC 1 1958

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

58-042921
STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3092 Registrar's No. 185

| | |
|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY Saline | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Saline |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall — Inside Limits Yes [X] No [ ] | c. CITY OR TOWN Marshall 0972 — Inside Limits Yes [X] No [ ] |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ~~XXXXXXX~~ Fitzgibbon Hosp. — Length of stay in 1b 6hrs. | d. STREET ADDRESS (If outside, give location) 369 W.Marion — Reside on Farm Yes [ ] No [X] |

3. NAME OF DECEASED (Type or print) First Winford Middle — Last Conway Jr.

4. DATE OF DEATH Month November Day 21 Year 1958

5. SEX Male 2

6. COLOR OR RACE Negro

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH November 21,58

9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR Months 0 Days 0 — IF UNDER 24 HRS. Hours 6 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (City and state or country) Marshall,Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Winford Conway

13b. MOTHER'S MAIDEN NAME Barbara Williams

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 Address Winford Conway,Marshall,Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Prematurity

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 776X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 Nov 21 1958, to Nov.21,1958 and last saw ~~her~~ him alive on 11-22-58

Death occurred at 11-22-58 5:45 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James A Reed MD

22b. ADDRESS Marshall Mo

22c. DATE SIGNED 11-22-58

23a. BURIAL, [redacted] (Specify) Burial

23b. DATE Nov 24, 1958

23c. NAME OF CEMETERY OR ~~CREMATORY~~ Union Hill Cemetery

23d. LOCATION (City, town, or county) (State) Union Hill N.E. Saline Co. Missouri

24. FUNERAL DIRECTOR George H. Green — ADDRESS Marshall Mo.

25. DATE RECD. BY LOCAL REG. 11-24-58

26. REGISTRAR'S SIGNATURE Cecil G. Reed

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

## 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 George H. Green

Licensed Embalmer No. 4220

P. O. Address Marshall, 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.