

Dr. Lemmon

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020948  
STATE FILE NUMBER

FILED JUL 7 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 703

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>MISSOURI</b> b. COUNTY <b>WRIGHT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>NORWOOD</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CONNELLY NURSING HOME</b>		Length of stay in lb <b>5 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>11</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>CONNOLLY</b> Last <b>CONNOLLY</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>26</b> Year <b>1959</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 5, 1873</b>
9. AGE (In years) <b>86</b> (birthday)		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>WRIGHT COUNTY, MO. C</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>MIKE McCarthy</b>	
13b. MOTHER'S MAIDEN NAME <b>WINIFRED O'CONNOR</b>		14. NAME OF HUSBAND OR WIFE <b>PETER L. CONNOLLY (DEC.)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT Address <b>MRS. J.W. LACHMUND SPRINGFIELD, MO.</b>
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>Arteriosclerosis, gen'd</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } 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 <b>Sev. yrs</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>4560</b>	
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 _____ Month, Day, Year _____ a.m. _____ 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 <b>1957</b> to <b>6-26-59</b> and last saw her alive on <b>6-26-59</b> Death occurred at <b>8:15 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Dr. Lemmon MD</b> (Degree or title)		22b. ADDRESS <b>Springfield, Mo.</b>	22c. DATE SIGNED <b>6-28-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6/29/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b> ADDRESS <b>SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6-29-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>

V. S. 300  
Rev. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18 1947, 10 21, 1947

1947, 10 21, 1947

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 *A. L. McCann* .....

Licensed Embalmer No. *2727* .....  
P. O. Address *Springfield, Miss* .....

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.