

FILED VS AUG 4 1959

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 234

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		c. CITY OR TOWN Kirksville	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION C N. H. # 1		d. STREET ADDRESS (If outside, give location) 711 S 6th	

3. NAME OF DECEASED (Type or print) First Middle Last Clarinda (Kate) Conley	4. DATE OF DEATH Month Day Year 7/28/59
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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 6/23/1871	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months 1 Days 5	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper	10b. KIND OF BUSINESS OR INDUSTRY domestic	11. BIRTHPLACE (City and state or country) Sullivan County, Mo USA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Jacob Stanley	13b. MOTHER'S MAIDEN NAME Sarah Bellas	14. NAME OF HUSBAND OR WIFE Wm. Conley
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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) no	16. SOCIAL SECURITY NO. -	17. INFORMANT Mrs. J. W. Zimmerman-KX
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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) Acute overwhelming toxicemia DUE TO (b) ascending urinary tract infection DUE TO (c) Chronic cystitis & urethritis	INTERVAL BETWEEN ONSET AND DEATH days weeks unknown
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from January 1958 to 7-28-59 and last saw her alive on 7-28-59 Death occurred at 9:35 A m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Dress or title) Georgette Scherer, D.O.	22b. ADDRESS Kirksville	22c. DATE SIGNED 7-30-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 7/30/59	23c. NAME OF CEMETERY OR CREMATORY Greencastle Cemetery	23d. LOCATION (City, town, or county) (State) Greencastle Mo
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24. FUNERAL DIRECTOR Davis & Davis	ADDRESS Kirksville	25. DATE RECD. BY LOCAL REG. 7-31-1959	26. REGISTRAR'S SIGNATURE Noris W. Rathff
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 4 1950

GEORGE H. SCHEURER, D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirkville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.