

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-024532**

**FILED VS JUL 20 1959**

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 54 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>CLINTON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CLINTON</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CAMERON</b>		Length of stay in 1b		c. CITY OR TOWN <b>CAMERON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CAMERON, HOSPT.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>620 E. 5th. St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>DORTHORY MAXINE CONNORS.</b>				4. DATE OF DEATH Month Day Year <b>July, 1st, 1959</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12.4.1921</b>	9. AGE (last birthday) <b>37</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR 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 <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>OSBOR N, KANS.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>WILLIAMS J. CONNORS</b>			13b. MOTHER'S MAIDEN NAME <b>IDA IRENE SLAYBAUGH</b>			14. NAME OF HUSBAND OR WIFE <b>SINGLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>497,32,3413</b>		17. INFORMANT Address <b>IDA IRENE CONNORS CAMERON, M</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>INTESTINAL OBSTRUCTION. 6,25,59.</b>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>IDIOCY, MICROCEPHALIC, AND</b>							
		DUE TO (c) <b>GENERAL PHYSICAL RETARDATION</b>							
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 type="checkbox"/> No <input type="checkbox"/> Unknown			
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 a.m. p.m.		Month, Day, Year							
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>6-25-59</b> to <b>7-1-51</b> and last saw her/him alive on <b>7-1-51</b> Death occurred at <b>11:51 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>A. W. Templeman, D.O.</b>				22b. ADDRESS <b>CAMERON, MO.</b>				22c. DATE SIGNED <b>8.7.59.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7.3.1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery.</b>		23d. LOCATION (City, town, or county) (State) <b>Cameron, Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>DeMoss Crunk. Cameron, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>7-11-59</b>		26. REGISTRAR'S SIGNATURE <b>Francis Crawford</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed DeMoss Crunk *DeMoss Crunk*

Licensed Embalmer No. 2533.

P. O. Address Cameron, Mo

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