URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–036772

STATE FILE NUMBER

FILED VS OCT 26 1959 175

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 101

NDED

1. PLACE OF DEATH
a. COUNTY: Lawrence
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Aurora — Length of stay in 1b: 2½ months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Aurora Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Lawrence Co.
c. CITY OR TOWN: Marionville — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Methodist Home — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: M. Last: Conover

4. DATE OF DEATH: Month October Day 20 Year 1959

5. SEX: Female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-17-1874
9. AGE (last birthday): 84
IF UNDER 1 YEAR: Months 11 Days 3
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory worker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Arcola, Illinois
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: George S. Conover
13b. MOTHER'S MAIDEN NAME: Mary Jane Riggs
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 495-05-5333
17. INFORMANT: O. B. Duffendack Address: Methodist Home for Aged, Marionville Mo.

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): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebro-Vascular Accid. — 10 days
DUE TO (c): Advanced Arteriosclerotic C.V.D. disease — mdy.
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 8-22-'58, to 9-20-'59 and last saw her/him alive on 9-20-'59
Death occurred at 9:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. McCallum (Degree or title) M.D.
22b. ADDRESS: 300 S. Elliott Aurora.
22c. DATE SIGNED: Oct. 21/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Oct. 22, 1959
23c. NAME OF CEMETERY OR CREMATORY: Arcola Cemetery
23d. LOCATION (City, town, or county) (State): Arcola, Illinois,

24. FUNERAL DIRECTOR: L. C. Sunidge ADDRESS: Marionville, Mo.
25. DATE RECD. BY LOCAL REG.: Oct. 21-1959
26. REGISTRAR'S SIGNATURE: Ora McNatt

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

US OCT 27 1959

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_____ Signed William A. Fulks
Signature of Student Embalmer

Licensed Embalmer No. 4658

P. O. Address Marionville

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