

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

FILED VS. DEC - 2 1959

59-039506

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 87

UNRECORDED

1. PLACE OF DEATH a. COUNTY <b>Dent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Missouri</b> COUNTY <b>Dent</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Salem</b>		Length of stay in 1b <b>years</b>	c. CITY OR TOWN <b>Salem</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>at home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>East 3rd</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>-</b> Last <b>Conaway</b>	4. DATE OF DEATH Month <b>Nov</b> Day <b>24</b> Year <b>1959</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-23-92</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	11. BIRTHPLACE (City and state or country) <b>Dent Co Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Dr R H Conaway</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Shortt</b>	14. NAME OF HUSBAND OR WIFE <b>Pearl Biggs Conaway</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>X</b>	17. INFORMANT Address <b>Mrs Pearl Conaway Salem Mo</b>
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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) <b>Carcinoma of stomach with Metastases to liver, Rt. lung and Rt. Bronchus</b>	INTERVAL BETWEEN ONSET AND DEATH <b>11/24/59</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <b>Gastric Ulcer. Chronic Arthritis.</b>	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
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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.) <b>No injury</b>
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20c. TIME OF INJURY Hour _____ 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.) <b>3/20/56</b>	20f. CITY, TOWN, OR LOCATION <b>11/24/59</b>	COUNTY _____ STATE _____
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21. I attended the deceased from <b>3/20/56</b> to <b>11/24/59</b> and last saw him alive on <b>11/24/59</b> Death occurred at <b>10 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>L.H. Hill</b> (Degree or title)	22b. ADDRESS <b>Salem, Mo 110</b>	22c. DATE SIGNED <b>11/26/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11-27-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Stonehill</b>	23d. LOCATION (City, town, or county) (State) <b>Dent Co Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Spencer Funeral Home Inc</b>	25. DATE RECD. BY LOCAL REG. <b>11/27/59</b>	26. REGISTRAR'S SIGNATURE <b>M.M. Clark, M.D. by au</b>
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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 Carl H. Spencer

Licensed Embalmer No. 2370

P. O. Address Salmon

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.