

REGISTRATION DISTRICT NO. 381 Primary Registration District No. 4615 REGISTRAR'S NO. 48

=60-022043

STATE FILE NUMBER

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS JUN 13 1960

DED

1. PLACE OF DEATH a. COUNTY Sullivan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Sullivan									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Milan		Length of stay in 1b 24 days		c. CITY OR TOWN Green City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Sullivan Co. Memorial Hosp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) No street address		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Walter Jacob Connell				4. DATE OF DEATH Month Day Year June 2, 1960									
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/22/1887		9. AGE (last birthday) 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY General farming		11. BIRTHPLACE (City and state or country) Milan, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME James Connell				13b. MOTHER'S MAIDEN NAME Polly Ann Dearing				14. NAME OF HUSBAND OR WIFE Laura Connell					
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. 494-40-8204		17. INFORMANT Mrs. Laura Connell, Green City, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>										INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Fall</i>													
DUE TO (c) <i>arteriosclerosis.</i>													
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 checked="" 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.) <i>Fell down stairs at home</i>									
20c. TIME OF INJURY Hour a.m. Month, Day, Year <i>10 4/27/60</i>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. CITY, TOWN, OR LOCATION <i>Green City, Sullivan, Mo</i>		COUNTY		STATE			
21. I attended the deceased from <i>July 9, 1960</i> to <i>July 11, 1960</i> and last saw her alive on <i>July 11, 1960</i> . Death occurred at <i>7:45 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Walter J. Connell</i> (Degree or title)				22b. ADDRESS <i>Green City, Mo</i>				22c. DATE SIGNED <i>6/4/60</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/4/1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION (City, town, or county) (State) Green City, Mo.					
24. FUNERAL DIRECTOR <i>Glenn E. Hartman, Green City, Mo.</i> ADDRESS				25. DATE RECD. BY LOCAL REG. <i>6-7-60</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. M. W. Beckett</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 7 1960

JUN 28 1960

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 Karl R. Lent

Licensed Embalmer No. 4689

P. O. Address Green City

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.