MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-007904
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1622

FILED FEB 16 1962

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF DOCUMENT
6			9-	

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5229 Wells — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Oliver Middle: Last: Conner

4. DATE OF DEATH: Month 2 Day 6 Year 62

5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 7-13-1900
9. AGE (last birthday): 61 — IF UNDER 1 YEAR: Months 6 Days 23 — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Mississippi
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Elijah Conner
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Newyear Conner

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.: ?
17. INFORMANT: Victoria Burkes Address: 5229 Wells Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hypertensive Cardiovascular Disease	Undet.
DUE TO (c)	443x	

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 1-24-62, to 2-6-62 and last saw her/him alive on 2-6-62
Death occurred at 7:07 a.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Sydney A Fraser MD
22b. ADDRESS: 2601 N. Whittier Street
22c. DATE SIGNED: 2-6-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-9-62
23c. NAME OF CEMETERY OR CREMATORY: Ebenezer
23d. LOCATION (City, town, or county) (State): Cotton Plant, Arkansas

24. FUNERAL DIRECTOR: Ellis Funeral Home, Inc. ADDRESS: 2820 Stoddard
25. DATE RECD. BY LOCAL REG.: 2-7-1962
26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

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_____
Signature of Student Embalmer

Signed Fulton E. Aulkin

Licensed Embalmer No. 4198

P. O. Address [illegible]

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.