

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE **042**

62-009936

1000

364

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____

FILED APR 2 1962

Primary Registration District No. _____

Registrar's No. _____

VS 300
Rev. 4/59

15117

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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF **M.B. Ames, M.D.**

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Buchanan | | a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 50 Yrs | c. CITY OR TOWN St. Joseph |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph State Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2510 North 5th |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | Month Day Year |
| First JOHN Middle EDWIN Last CONNER | | March 27, 1962 | |
| 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 1-30-1885 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (12) Press Feeder | | 10b. KIND OF BUSINESS OR INDUSTRY Printing | 9. AGE (last birthday) 77 |
| 11. BIRTHPLACE (City and state or country) Osceola, Nebr. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Rodney Conner | | 13b. MOTHER'S MAIDEN NAME Isabelle Bassoar | |
| 14. NAME OF HUSBAND OR WIFE Marie L. Conner | | 17. INFORMANT Marie L. Conner | |
| 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. _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Arteriosclerotic heart disease | | 4 months | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Generalized arteriosclerosis | |
| | | DUE TO (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Brain Syndrome Multiple decubiti | | 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 _____ viewed the body to _____ the body saw him alive on 3/27/62 Death occurred at _____ 1:57 m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Mary Blanes, M.D. | | 22b. ADDRESS St. Joseph, Missouri | 22c. DATE SIGNED 3/27/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Mar. 29, 1962 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 23d. LOCATION (City, town, or county) St. Joseph, Mo. |
| 24. FUNERAL DIRECTOR H.O. Sidenfader & Son | | 25. DATE RECD. BY LOCAL REG. Mar. 29, 1962 | 26. REGISTRAR'S SIGNATURE Mr. Clark Goodell |
| ADDRESS St. Joseph Mo | | | |

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 Robert L. Geyer

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.