

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-044092**

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11861

DO NOT WRITE ON THIS STUB

AMENDED

**FILED DEC 14 1962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>1021 No. Cardinal</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Juanita</b> Middle <b>(Conley)</b> <b>CONLEY</b>		4. DATE OF DEATH Month <b>12</b> Day <b>7</b> Year <b>62</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</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>3-15-1928</b>
9. AGE (last birthday) <b>34</b>		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) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>OAKLAND, Miss.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>		13a. FATHER'S NAME <b>LOUIS NORWOOD</b>	
13b. MOTHER'S MAIDEN NAME <b>ERNESTINE REED</b>		14. NAME OF HUSBAND OR WIFE <b>TOMMIE CONLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		17. INFORMANT Address <b>HALLIE LARRY 1249<sup>th</sup> JEFF ME.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Ureteral Obstruction</b>			
DUE TO (c) <b>Cancer of Cervix</b>			
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 checked="" 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.) <b>171x</b>	
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 <b>9-25-62</b> to <b>12-7-62</b> and last saw <del>her</del> <b>him</b> alive on <b>12-7-62</b> Death occurred at <b>11:30 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Wm. Smalley</i> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>12-10-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-13-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMPHIS, TENN.</b>	
24. FUNERAL DIRECTOR <b>McCLAIN</b>	ADDRESS <b>1841 CASS</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 11 1962</b>	26. REGISTRAR'S SIGNATURE <i>Wm. Smalley</i> <b>M.D.</b>

VS 300 Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DATE AMENDED

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

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STATEMENT BY LICENSED EMBALMER

MISSISSIPPI DEPARTMENT OF HEALTH

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

*Malcolm R. Williams*

Licensed Embalmer No. 4926

5135 Latus

P.O. Address \_\_\_\_\_

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.