

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

REC'D JAN 13 1939

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

41903
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Jean Primary Registration District No. 1002
 (c) City Jackson (d) Street No. 22 C Genl Hrdg St.
 (If death occurred in hospital or institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 563 Edward Comad St.
Little Sisters of Poor (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3 1868
 7. AGE YEARS 70 MONTHS 6 DAYS 18 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Stalped
 9. Industry or business in which work was done, as saw mill, bank, etc. Dentist
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER 13. NAME Thomas Comad

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

MOTHER 15. MAIDEN NAME Mary Dwy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

17. INFORMANT (ADDRESS) Deirda Clark

18. BURIAL, CREMATION, OR REMOVAL PLACE St Joseph Mo DATE 12/21/38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) F O Donnell
3756 Broadway

20. FILED Dec 22 1938 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-21 1938

22. I HEREBY CERTIFY, That I attended deceased from 12-19 1938 to 12-21 1938

I last saw him alive on 12-21 1938 Death is said

to have occurred on the date stated above, at 4:25 am

The principal cause of death and related causes of importance were as follows:

Cerebral sclerosis,
Encephalocystic
Cerebral sclerosis
Other contributory causes of importance:
Chronic Myocarditis
with Nephritis, Chronic

Date of onset

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 1938

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) P. DeMarco M. D.

(Address) St Joseph Mo

131

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE MUST BE STATED EXACTLY. PHYSICIAN'S SIGNATURE SHOULD BE PLACED IN THIS SPACE. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION ON THIS FORM MUST BE PLACED IN THIS SUPPLEMENTARY SPACE

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township R.C. Primary Registration District No. 1022
City R.C. (No. R.C. Ben. Hosp.)

File No. 41903
Registered No. 4969-
St. _____ Ward _____

2. FULL NAME

Edward Conrad
(a) Residence, No. Little Sisters of Poor St. _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED D-
(Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day or min.
70 6 18

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED Dec 24 1938 J. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 21 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cerebral Sclerosis (Anterior cuneus)
Encephalomalacia
Cerebral Sclerosis
Other contributory causes of importance:
Chr. Myocarditis | 2 |
Chr. Nephritis

Date of onset

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) P. F. De Munn, M. D.

(Address) Ben. Hosp.

