

1 X19811 MISSOURI STATE BOARD OF HEALTH

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 548

Primary Registration District No. 4323

Registrar's No. 5

1. PLACE OF DEATH:

(a) County MARION

(b) City or town PALMYRA Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community ENTIRE LIFE
years, months or days

3. (a) PRINT FULL NAME PEARL L CONNER 560

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased APR. 17 1877
(Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace MARION County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE KEEPER

11. Industry or business _____

MOTHER FATHER { 12. Name MARION HAM

13. Birthplace NOT KNOWN
(City, town, or county) (State or foreign country)

14. Maiden name JULIA WARREN

15. Birthplace NOT KNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Henry Conner

(b) Address Palmyra Mo.

17. (a) SANDERS CEM. (b) Date thereof 1-21-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MARION Co. Mo.

18. (a) Signature of funeral director A. M. Sprague

(b) Address Palmyra Mo.

19. (a) Jan 27-1940 (b) Gertrude Lee
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Marion

(c) City or town Palmyra
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20
year 1940 hour 10 AM minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____;

and that death occurred on the _____ date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 1/2 hr

Due to No history

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature A. M. Sprague (M. D. or other) _____

Address Palmyra Mo. Date signed _____

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

A. M. Sprague

Licensed Embalmer No.

999

P. O. Address

Palmyra, Md.

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.