No. 2
1-10-39
17-39
X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUN 17 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 17760

Registration District No. 804 Primary Registration District No. 5003 Registrar's No. 127

**1. PLACE OF DEATH:**
(a) County: Adair
(b) City or town: Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Greentop R. F. D.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 In this community 70 years (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Missouri (b) County: Adair
(c) City or town: Greentop Rural (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME: Russell Conner 560
3. (b) If veteran, name war: ____
3. (c) Social Security No.: none
4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Hattie Conner
6. (c) Age of husband or wife if alive: 0061 years
7. Birth date of deceased: ~~Adair County Missouri~~ Nov. (Month) 24 (Day) 1869 (Year)
8. AGE: Years 70 Months 6 Days 5 If less than one day ____ hr. ____ min.
9. Birthplace: Adair County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: farm
12. FATHER Name: William Conner
13. FATHER Birthplace: ____ (City, town, or county) Missouri (State or foreign country)
14. MOTHER Maiden name: Emaline Crow
15. MOTHER Birthplace: ____ (City, town, or county) Tennessee (State or foreign country)
16. (a) Informant: Mrs. Hattie Conner
(b) Address: Greentop Mo. R. F. D.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-31-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Fort Maddison Cemt.
18. (a) Signature of funeral director: Dee Riley
(b) Address: Kirksville Mo.
19. (a) June 4/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 29 year 1940 hour 9:00 AM minute ____ M.
21. I hereby certify that I attended the deceased from ____, 1938, to May 29, 1940, that I last saw him alive on May 26, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Mitral insufficiency (Chronic endocarditis) — Duration
Due to: age
Due to: G.I.W.
Other conditions (Include pregnancy within 3 months of death): Cardiac asthma

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: L. J. Conner (M. D. or other)
Address: Kirksville Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 6-40-1229
Date Filed JUN 13 1940

**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 Laura Riley, Registered Apprentice No. ..... working under my personal supervision.

Signed Laura Riley
Licensed Embalmer No. 3907
P. O. Address Kirksville Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

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