

Registration District No. 263

Primary Registration District No. 6137

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural - Near Bucyrus Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Piney Jwp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Jeff Conner

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Sm 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Oct 8 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name W. B. Conner

13. Birthplace Pa.
(City, town, or county) (State or foreign country)

14. Maiden name Abbie Moody

15. Birthplace Ala.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Grover Cross

(b) Address Bucyrus Mo

17. (a) Burial (b) Date thereof 1/12/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Houston

18. (a) Signature of funeral director Raymond J. Elliot

(b) Address Houston Mo

19. (a) Jan 11 1941 (b) Michael Shacklett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas¹⁰⁷
(c) City or town Bucyrus⁰
(If outside city or town limits, write "RURAL")
(d) Street No. Piney Jwp⁰
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9
year 1941 hour _____ minute _____ M.

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

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 9

23. Signature W. B. Hubbard (M. D. or other) _____

Address Houston Mo Date signed 1-10-41

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

MOTHER FATHER

RECEIVED
District Health Officer No. 5,
District File Number. 241250
Date Filed _____

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 Gaylor V. Elliott
Licensed Embalmer No. 2252
P. O. Address Carol 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 this body is not embalmed, above space should be left blank.