

Registration District No. **24-811**

Primary Registration District No. **5-0976055**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Rockville, Mo. #1 (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none Inher Jump
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Clair
(c) City or town Rockville, Mo. (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. 1 3/4 miles S.E. of Rockville
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minnie Louisa Conrad

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Wm Conrad 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Mar. 17 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 10 19 hr. min.

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

10. Usual occupation Farmer's wife

11. Industry or business _____

12. Name Edward E. Endicott

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

14. Maiden name Mattie Millan

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

16. (a) Informant William Conrad

(b) Address Rockville Mo

17. (a) burial (b) Date thereof Feb. 8, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rockville Cemetery

18. (a) Signature of funeral director Eckhoff Funeral Home

(b) Address Aspetau City, Mo.

19. (a) Feb 8, 1945 (b) Mrs. Wilber Steiner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 5
year 1945 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan. 1
1941, to Feb. 5, 1945;
that I last saw her alive on Feb. 5, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Anemia Duration 2 weeks

Due to Bright's Disease 5 yrs.
Due to Nephritis 8 yrs.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

Major findings: Of operations none performed Of autopsy none performed
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 2

23. Signature M. O. Bjenke (M. D. or other) D.O.
Address Rockville, Mo Date signed 2/8/45

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

MOTHER FATHER

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 Paul J. Weston

Licensed Embalmer No. 3990

P. O. Address Oscoda 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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. MarchRegistration District No. 311Primary Registration District No. 6055

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Rural - Lake Park
(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 whetherIn this community _____
years, months or days)3. (a) PRINT FULL NAME Minnie L. Conrad

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

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

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

7. Birth date of deceased March 17 1965
(Month) (Day) (Year)8. AGE: Years 53 Months 10 Days 14 If less than one day _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25
year 1965 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____ 19 _____;
that I last saw him _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____ Duration _____

Due to Chronic Bright's disease 5 yrs.Due to 12/18/64

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 M. C. Birke (M. D. or other) P.O.Address Rockville, Mo. Date signed 3/19/65

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

MOTHER FATHER

6994