

S. No. 2  
DM-5-43  
v. 5-17-39  
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DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED DEC 6 1945

STANDARD CERTIFICATE OF DEATH

State File No. 36117

Registrar's No. 4822

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
9 months (Specify whether  
 In this community 0  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3152 Bell  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Walter P. Conner  
 (b) If veteran, name war No  
 (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov. day 22  
 year 1945 hour 4 minute 45 A.M.

4. Sex Ma 5. Color or race Wh  
 6. (a) Single, widowed, married, divorced Widowed  
 (b) Name of husband or wife Amanda Conner  
 (c) Age of husband or wife if alive XX years  
 7. Birth date of deceased July 10 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 20 1945 to Nov. 22 1945  
 that I last saw him alive on Nov. 22 1945  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
84 4 12 hr. min.

Immediate cause of death Bronchopneumonia; Perforation of pylorus of stomach with localized peritonitis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Retired Farmer

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy See above  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business No Record  
 12. Name Conner  
 13. Birthplace 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name Amy McCombs  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edith Heldstab  
 (b) Address 3152 Bell  
 17. (a) Burial (b) Date thereof 11-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Eldon, Missouri

22. If death was due to external causes, fill in 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? \_\_\_\_\_

18. (a) Signature of funeral director J.W. Wagner  
 (b) Address Kansas City, Mo.  
 19. (a) 11-24-45 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

23. Signature Clark W. Seely  
(Specify type of place) (City or town) (County) (State)  
 Address Med. Dir. Gen'l Hosp. Date signed 11-23-45

(Licensed Embalmer's Statement on Reverse Side)

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

**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 Alvin R. Hamschild

Licensed Embalmer No. 4159

P. O. Address Kansas City 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State Filed No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4822

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
Gen. Hosp. #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Walter P. Conner

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_

5. Color or race \_\_\_\_\_

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11-24-45 (b) Geraldine Holmes  
(Date received local registrar) (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) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22  
year 1945 hour 4 minute 45 a.m.

21. I hereby certify that I attended the deceased from Nov. 20 1945 to 11-22 1945  
that I last saw im alive on 11-22 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death broncho pneumonia

Due to perforation of pylorus of stomach with localized peritonitis

Due to peptic ulcer

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations 1170<sup>2</sup>

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

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 Clark W. Seely (M. D. or other) \_\_\_\_\_  
Address Gen Hosp. Date signed 11-23-45

SUPPLEMENTAL

36117