U. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38742

FILED DEC 12 1945

Registration District No. 534 Primary Registration District No. 6132 Registrar's No.

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

1. PLACE OF DEATH:
(a) County SHANNON
(b) City or town RURAL (Mount Hope)
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County SHANNON 101
(c) City or town — RURAL 0
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR BUNKER, MO 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME LILLIE CONWAY
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced M 1
6. (b) Name of husband or wife LINK CONWAY
6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased JUNE (Month) 5 (Day) 1895 (Year)

8. AGE: Years 50 Months 5 Days 14 If less than one day hr. min.

9. Birthplace JEFFERSON CO. (City, town, or county) MO 0 (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business
FATHER 12. Name CALVIN WARREN
13. Birthplace TENN (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name MIRINDA MEDLEY
15. Birthplace JEFFERSON CO (City, town, or county) MO. 0 (State or foreign country)
16. (a) Informant Link Medley
(b) Address Bunker Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Conway Cem.
18. (a) Signature of funeral director Carl X. Spencer
(b) Address Salem, Mo.
19. (a) 12-8-45 (Date received local registrar) (b) Walter Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 19 year 1945 hour 10:35 minute A. 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.

	Duration
Immediate cause of death Paralysis	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature L. L. Henson (M. D. or other)
Address Bunker, Mo. Date signed 11-23-45

1497 (Licensed Embalmer's Statement on Reverse Side)

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 Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address: Salem, 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.