

FILED MAR 27 1946

Registration District No. **349**

Primary Registration District No. **4514**

Registrar's No. **4**

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Green City Mo.
(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
years, months or days) Life (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan
(c) City or town Green City
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Washington Conkin

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

4. Sex M 0 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased 11 22 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
88 2 24 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name J. J. Conkin

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

14. Maiden name Sarah Burke

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

16. (a) Informant C. G. Conkin

(b) Address Green Castle Mo.

17. (a) Burial (b) Date thereof 2 18 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green City Cemetery

18. (a) Signature of funeral director Wm. E. Paul
(b) Address Green City Mo.

19. (a) Feb. 28 46 (b) Leola M. Spaulding
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16
year 1946 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov 1
2 1946 to Feb 16 1946
that I last saw him alive on Feb 15 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
MYOCARDIAC HEART FAILURE
Due to VALVULAR HEART DISEASE

Due to _____
Other conditions (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) (c) Means of injury _____
23. Signature W. E. Paul (M. D. or other)
Address Green City Mo. Date signed 2-8-46

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 3-46552

Date Filed MAR 19 1946

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..... Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address..... Green Lake

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.

Registration District No. 349

Primary Registration District No. 451X

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Shewan city
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Saicha Conkin

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 _____

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

7. Birth date of deceased Feb 28 (Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hr. _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1946 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 _____

Duration _____

Due to Rheumatism with which she had for years
Due to _____

Other conditions _____ (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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11948