

Registration District No. 38

Primary Registration District No. 300.6

Registrar's No. 86

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

3  
2  
7

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:  
Boone County Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days  
(Specify whether in this community 23 Yrs. years, months or days)

3. (a) PRINT FULL NAME George Warren Conner

3. (b) If veteran, name war None

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

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Omah B. Lane Conner

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

7. Birth date of deceased 6 - 30 - 1882  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>8</u>	<u>20</u>	_____ hr. _____ min.

9. Birthplace Yorkshire England  
(City, town, or county) (State or foreign country)

10. Usual occupation Insurance Salesman

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

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Geo. W. Conner

(b) Address 503 Locust St., Columbia, Mo.

17. (c) Burial (b) Date thereof 3-23-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Parker Funeral Service

(b) Address Columbia, Mo.

19. (a) 3-24-48 (b) Mrs. R.E. Palmer  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Columbia  
(If outside city or town limits, write "RURAL")

(d) Street No. 503 Locust St.  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20  
year 1948 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Mar 15  
1948 to Mar 20, 1948

that I last saw him alive on Mar 20  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to arteriosclerosis

Due to \_\_\_\_\_

Other conditions chronic nephritis  
(Include pregnancy within 3 months of death) chronic myocarditis

Major findings:  
Of operations \_\_\_\_\_

Of autopsy: 131 B

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 H.M. Hill (M. D. or other) M.D.

Address Columbia, Mo. Date signed 3-23-48

RECEIVED  
DISTRICT HEALTH OFFICER NO. 9  
MAR 30 1948

1570 1948

**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 Tom M Harg  
Licensed Embalmer No. 4067  
P. O. Address Columbia, 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.**