

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6304

State File No.

Registrar's No. 1283

FILED MAR 5 1952

BIRTH NO.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE ILL.
b. COUNTY
c. CITY (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) SAM
b. (Middle) CONNER.
c. (Last)
4. DATE OF DEATH (Month) (Day) (Year) 2-8-52

5. SEX MALE
6. COLOR OR RACE NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 7-16-1902
9. AGE (In years last birthday) 49
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY R.R.
11. BIRTHPLACE (State or foreign country) Macon, Miss.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Reece Conner
13b. MOTHER'S MAIDEN NAME Lucy Ann Young
14. NAME OF HUSBAND OR WIFE Hattie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. -
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hattie Conner, Morphysboro, Ill.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION
Erebellar Hemorrhage
INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive C.V. Dis.
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Acute Gastritis & Hemorrhage

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR? 442X

22. I hereby certify that I attended the deceased from 1-7-1952 to 2-8-1952, that I last saw the deceased alive on 2-8-1952, and that death occurred at 4:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Charles Frouer, M.D.
23b. ADDRESS 440 Pac Hosp.
23c. DATE SIGNED 2/9/52

24a. BURIAL, CREMATION, REMOVAL (Specify) removal
24b. DATE 2-9-52
24c. NAME OF CEMETERY OR CREMATORY Tower Grove Cemetery
24d. LOCATION (City, town, or county) (State) Morphysboro, Ill.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 9 1952 J. Carl Smith, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell Und. Co. 2732 Pine Blvd

(Licensed Embellisher's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *James A. Carter*
Licensed Embalmer No. *4681*

P. O. Address *4923 Suburban*

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.