

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

J. WILLIAMS

17699

State File No. \_\_\_\_\_

FILED JUN 1 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 489-A

0396  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>		
b. CITY (If outside corporate limits, write RURAL and give township) <b>SPRINGFIELD</b>		c. LENGTH OF STAY (In this place) <b>5 1/2</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>SPRINGFIELD</b>		0396
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>MARY E. WILSON HOME</b> 924 North Main			d. STREET ADDRESS (If rural, give location) <b>MARY E. WILSON HOME</b> 924 North Main		

3. NAME OF DECEASED (Type or Print) a. (First) <b>FLORENCE</b> b. (Middle) <b>CONKLIN</b> c. (Last) <b>MENDENHALL</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 21, 1953</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>NOV. 17 1868</b>		9. AGE (In years last birthday) <b>84</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>KANSAS CITY, KANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>JERROD L. CONKLIN</b>		13b. MOTHER'S MAIDEN NAME <b>SUE GRAVES</b>		14. NAME OF HUSBAND OR WIFE <b>X</b>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown?) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MRS. HOWARD SHARP SPRINGFIELD</b>		
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio-sclerosis - generalized</b> DUE TO (c) <b>Senility</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>331X</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 7-28-52, to 5-21-53, that I last saw the deceased alive on 5-1-53, 1953, and that death occurred at 5p m., from the causes and on the date stated above.

23a. SIGNATURE (Describe or title) <i>[Signature]</i>		23b. ADDRESS <b>Springfield Mo</b>		23c. DATE SIGNED <b>5-22-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>5/23/53</b>	24c. NAME OF CEMETERY OR CREMATOR <b>MAPLE PARK</b>	24d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>	
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DATE RECD BY LOCAL REG. <b>5-23-53</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H. H. LOHMEYER SPRINGFIELD, MO.</b>	
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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Lucius T. Swalley

Licensed Embalmer No. 4815

P. O. Address Springfield

**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.**