

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **51**
Registrar's No. **8**

FILED JAN 17 1955

BIRTH NO. _____ REG. DIST. NO. **10** PRIMARY REG. DIST. NO. **3002**

1. PLACE OF DEATH a. COUNTY Audrain County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Audrain	
b. CITY (If outside corporate limits, write RURAL and give township) Mexico		c. CITY OR TOWN Centralia	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 5 days		e. STREET ADDRESS (If rural, give location) Route 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION Audrain County Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) Geraldine c. (Last) Conley			4. DATE OF DEATH (Month) (Day) (Year) Jan. 10 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 3, 1939	9. AGE (In years last birthday) 15	if UNDER 1 YEAR: Months 2 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and State or Foreign Country) Centralia, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Raymond Monroe Conley		13b. MOTHER'S MAIDEN NAME Evelyn Ann Murphy		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Evelyn Ann Conley, Centralia, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac Decompensation		DUE TO (b) Memia			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Chronic Nephritis			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		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 **Dec 13, 1954** to **Jan 10, 1955**, that I last saw the deceased alive on **Jan 10, 1955**, and that death occurred at **1:00 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert L. Ward M.D.		23b. ADDRESS Centralia, Mo		23c. DATE SIGNED Jan 11, 1955	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Jan. 12, '55		24c. NAME OF CEMETERY OR CREMATORY City of Centralia	
24d. LOCATION (City, town, or county) (State) Centralia, Missouri					

DATE REC'D BY LOCAL REG. Jan 12, 1955		REGISTRAR'S SIGNATURE Blanche Neely		25. FUNERAL DIRECTOR'S SIGNATURE Dell W. Mesler, Centralia, Missouri	
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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Bill Mendo*.....

Licensed Embalmer No. *4870*

P. O. Address *Centralia, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.