

FILED SEP 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29683

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3984</u>			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jackson City</u>		c. LENGTH OF STAY (in this place) <u>2 wks.</u>		c. CITY OR TOWN <u>Sedalia</u>		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				e. STREET ADDRESS <u>Sedalia</u> (If rural, give location) <u>0401</u>					
3. NAME OF DECEASED a. (First) <u>JOHN</u> (Type or Print)			b. (Middle) <u>HUMPHREY</u>		c. (Last) <u>CONNOR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 12 1955</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>2/3/77</u>		9. AGE (In years last birthday) <u>78</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Lamar, Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Connor</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Shea</u>			14. NAME OF HUSBAND OR WIFE <u>Oliver Connor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>493-14-7578</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Margaret Brennan K.D. Mo.</u>				ADDRESS _____	
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, asthenia, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myelogenous Leukemia</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>5041</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? _____					
22. I hereby certify that I attended the deceased from <u>Aug 30</u> , 19 <u>55</u> , to <u>Sept 12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>55</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Bernell W. Andrews, M.D.</u> (Degree or title)					23b. ADDRESS <u>Prof. Bldg. Kansas City Mo.</u>			23c. DATE SIGNED <u>9/12/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reinterred</u>		24b. DATE <u>Sept. 12-1955</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) <u>Sedalia, Missouri</u>		(State) _____	
DATE REC'D BY LOCAL REG. <u>9-12-55</u>		REGISTRAR'S SIGNATURE <u>Reva Marshall</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>C.H. Blackman Son Inc.</u> ADDRESS _____				

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..... *W.C. Rine* .....

Licensed Embalmer No. *4879*.....

P. O. Address..... *K.C. 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.