

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19885

State File No. ....

FILED MAY 22 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 369 PRIMARY REG. DIST. NO. 4539 Registrar's No. 2

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Wayne</u>                            |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission).<br>a. STATE <u>Mo</u> b. COUNTY <u>Wayne</u> |   |
| b. CITY OR TOWN <u>Williamsville</u> c. LENGTH OF STAY (in this place) |  | c. CITY OR TOWN <u>Williamsville</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                                |  | STREET ADDRESS (If rural, give location) <u>1110</u>  |   |

|   |  |   |  |
|---|--|---|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Jobe</u> b. (Middle) <u>Condray</u> c. (Last) <u>Condray</u> |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 6 1957</u>                   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>                    | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>     | 8. DATE OF BIRTH <u>June 28 1882</u>       |
| 9. AGE (In years last birthday) <u>74</u>   | IF UNDER 1 YEAR Months <u>10</u> Days <u>8</u>   | IF UNDER 24 HRS. Hours <u></u> Min. <u></u>                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Carter Co., Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |

|  |                                       |  |
|--|---------------------------------------|--|
| 13a. FATHER'S NAME <u>Kasper Condray</u> | 13b. MOTHER'S MAIDEN NAME <u>D.K.</u> | 14. NAME OF HUSBAND OR WIFE <u>Minnie Carnahan Condray</u> |
|--|---------------------------------------|--|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME <u>Norvin Condray</u> ADDRESS <u>Mill Springs Mo.</u> |
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|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebral arteriosclerosis myocardial insufficiency</u>  |  |                                  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <u>Terminal pneumonia</u> |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |                                  |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>334x</u> | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 <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 4/28, 1957, to 4/28, 1957, that I last saw the deceased alive on 4/28, 1957, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|  |                                  |                                 |
|--|----------------------------------|---------------------------------|
| 23a. SIGNATURE <u>H. H. Cline M.D.</u> (Degree or title) | 23b. ADDRESS <u>Piedmont Mo.</u> | 23c. DATE SIGNED <u>5/10/57</u> |
|--|----------------------------------|---------------------------------|

|   |                         |  |   |
|---|-------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>5/8/57</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Robertson Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>Ellisnore Carter Co. Mo.</u> |
|---|-------------------------|--|---|

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|--|---|--|
| DATE REC'D BY LOCAL REG. <u>May 16, 1957</u> | REGISTRAR'S SIGNATURE <u>Hazel Ward</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>William Beck</u> ADDRESS <u>Piedmont Mo.</u> |
|--|---|--|

No. 300  
10-48

110

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

60

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 Coder Funeral Home, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William Coder

Licensed Embalmer No. 372

P. O. Address Piedmont

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.