

FILED APR 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012981
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 45

300
-57

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1. PLACE OF DEATH a. COUNTY <i>Vernon</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Greene</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Washington township</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>Springfield</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hospital #3</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>Unknown</i>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <i>Druly</i> Middle <i>-</i> Last <i>Conn</i>			4. DATE OF DEATH Month <i>3</i> Day <i>30</i> Year <i>1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1.29.1881</i>	9. AGE (In years last birthday) <i>77</i>	IF UNDER 1 YEAR Months <i>2</i> Days <i>1</i>	IF UNDER 24 HRS. Hours <i>-</i> Min. <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (City and state or country) <i>Greene Co. O</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>David Conn</i>		13b. MOTHER'S MAIDEN NAME <i>Elizabeth Chambers</i>		14. NAME OF HUSBAND OR WIFE <i>divorced.</i>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Records State Hospital # Nevada, Mo.</i>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>several years</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<i>4500</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chronic Brain Syndrome ex. C. Disturbance of Metabolism Psychotic reaction</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <i>/</i>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	<i>2</i>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from *2.8.1956* to *3.30.1958* and last saw her/him alive on *3.30.58. at 10:00 AM.*
Death occurred at *12:50 P.* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>George Esker M.D.</i>	(Degree or title)	22b. ADDRESS <i>State Hospital #3 Nevada, Mo.</i>	22c. DATE SIGNED <i>3.30.1958</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>4-2-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Brookline</i>	23d. LOCATION (City, town, or county) (State) <i>Brookline Mo</i>
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24. FUNERAL DIRECTOR <i>Ray Piny Springfield</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>4-1-1958</i>	26. REGISTRAR'S SIGNATURE <i>Anna E. Ferry</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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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 _____
Signature of Student Embalmer

Signed *[Handwritten Signature]* _____

Licensed Embalmer No. 3312

P. O. Address *[Handwritten Address]*

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.