

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002066
STATE FILE NUMBER

FILED JAN 30 1959

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 16

300
-57

1. PLACE OF DEATH a. COUNTY <u>MACON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MACON, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>1022 R.F.D. CLARENCE, Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SAMARITAN Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>CLARENCE, Mo. R.F.D.</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JACOB LEONARD CONARD</u>			4. DATE OF DEATH Month Day Year <u>JAN 11 1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 14, 1872</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days 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 country) <u>SHELBY COUNTY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>LEVI CONARD</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH MAYNOR</u>		14. NAME OF HUSBAND OR WIFE	

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>no</u>	17. INFORMANT <u>MRS NORMA TRACEY, CLARENCE, Mo.</u>	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) <u>CARDIO-RENAL-VASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>HYPERTENSION</u>	<u>YEARS</u>
	DUE TO (c) <u>ARTERIOSCLEROSIS</u>	<u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>RHEUMATOID ARTHRITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from 9-18-1954, to 1-11-1959 and last saw ^{him} alive on 1-11-1959
Death occurred at 7:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Alfred R. Hull</u>	(Degree or title) <u>D.O.</u>	22b. ADDRESS <u>Clarence, Mo</u>	22c. DATE SIGNED <u>1-23-1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 14, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>SHELBY COUNTY, MISSOURI</u>
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24. FUNERAL DIRECTOR <u>GREENING</u>	ADDRESS <u>CLARENCE, MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 26 / 59</u>	26. REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 24 1959

Date Filed 1-29-59

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 *Charles V. Green*

Licensed Embalmer No. *4625*

P. O. Address *Claremont*

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.