

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024927

FILED VS JUL 27 1959

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 88 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Worcester</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in 1b <u>19 yrs</u>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1014 Davidson</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>1014 Davidson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Wm Joseph Conway</u> First Middle Last			4. DATE OF DEATH <u>7-19-59</u> Month Day Year			
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>9-22-1871</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>27</u>	IF UNDER 24 HR Hours <u>27</u> Min. <u></u>
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>rent</u>	11. BIRTHPLACE (City and state or country) <u>Mo. USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>Pat Conway</u>		13b. MOTHER'S MAIDEN NAME <u></u>	14. NAME OF HUSBAND OR WIFE <u></u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Alfred Conway, West Plains Mo</u> Address

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>Cardiovascular renal disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>generalized arteriosclerosis</u>		<u>5 years</u>
DUE TO (c) <u></u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uremia.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.) <u></u>	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u></u>

21. I attended the deceased from 5/1/59 to 7/19/59 and last saw him alive on 7/19/59
Death occurred at 7:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. L. Fowler MD</u>		22b. ADDRESS <u>West Plains Mo</u>		22c. DATE SIGNED <u>7/22/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>	23b. DATE <u>7-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wagner</u>	23d. LOCATION (City, town, or county) (State) <u>Salem Mo</u>	
24. FUNERAL DIRECTOR <u>Charles M West Plains Mo</u>		25. DATE RECD. BY LOCAL REG. <u>7-26-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT-BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert

Licensed Embalmer No. 343
P. O. Address 1111 570

Note: The above, MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.