

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1948

Registration District No. 360

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6225

State File No. 28674

Registrar's No. 121

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Washington Twp. rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #3-2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 yrs. 11 mos. 13 d.
(Specify whether
In this community 19 yrs. 11 mos. 13 days
years, months or days)

3. (a) PRINT FULL NAME George W. Mc Connell

3. (b) If veteran, name war ? 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ? 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased 4-13-?
(Month) (Day) (Year)

8. AGE: Years 80 Months 0 Days 0 If less than one day hr. ? min. ?

9. Birthplace D.K.
(City, town, or county) (State or foreign country)

10. Usual occupation Harness Maker

11. Industry or business

MOTHER FATHER { 12. Name Samuel M. Connell
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Ida Sanders
15. Birthplace D.K.
(City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address State Hospital #3, rural

17. (a) Removed (b) Date thereof 8-28-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation California, Mo.

18. (a) Signature of funeral director Funeral Home

(b) Address New Ada, Mo.

19. (a) 8-28-48 (b) W. H. Hays
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
(c) City or town Warrensburg
(If outside city or town limit, write "RURAL")
(d) Street No. D.K.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 27
year 1948 hour 2:25 minute 7 M.

21. I hereby certify that I attended the deceased from 6-1- 1946 to 8-27- 1948
that I last saw him alive on 8-27- 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Liver

Due to meningitis Encephalitis

Due to Arteriosclerosis

Other conditions ?
(Include pregnancy within 3 months of death)

Major findings: Of operations 4/4

Of autopsy 4/4

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work? (e) Means of injury

23. Signature W. H. Hays (M. D. or other)

Address State Hospital #3 Date signed 8-27-48

RECEIVED

District Health Officer No. 7;

District File Number 8-48-1015

Date Filed 9-8-48

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. 1760

P. O. Address Wade Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.