N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D MAY 18 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

16232
Do not use this space.

1. PLACE OF DEATH
(a) County Saline 2 Registration District No. 796
(b) Township 1 Primary Registration District No. 3038 Registered No. 77
(c) City Marshall (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John W. McCue
(a) Residence, No. 649 E. West St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE Col.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Callie McCue
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 18 - 1852
7. AGE YEARS 87 MONTHS 7 DAYS 5 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Old age Rendrover
9. Industry or business in which work was done, as saw mill, bank, etc. X
10. Date deceased last worked at this occupation (month and year) X
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) X Saline Co Mo

FATHER
13. NAME John W. McCue
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Unknown

17. INFORMANT (ADDRESS) Callie McCue Marshall Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Finchcreek TP DATE April 26 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. D. Ferguson Marshall
20. FILED 4-26-39 Mary Kent Deep Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-23 1939
22. I HEREBY CERTIFY, That I attended deceased from 11-1 1938, to 4-23 1939
I last saw him alive on 4-23 9 P 1939. Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Uremia	4-16-39
137	
Other contributory causes of importance: Prostatic	1930

Name of operation Hypertrophy Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury ....., 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) [signature], M. D.
(Address) Marshall Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6/9/89

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 F. D. Ferguson

Licensed Embalmer No. 2192

P. O. Address.....

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

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