

REC'D OCT 12 1939 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32529
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 384
(b) Township _____ Primary Registration District No. 4227 Registered No. _____
(c) City West Plains (d) Street No. Christa Hogan Hospital 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. 8 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Everett McCrary

(a) Residence, No. _____ St. Fayette, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 15, 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Rains McCrary

22. I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1939, to Aug 15, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan-12, 1882

I last saw h. im. alive on Aug. 14, 1939 Death is said

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
57 7 3

to have occurred on the date stated above, at 4:40 A.M.
The principal cause of death and related causes of importance were as follows:

Intestinal obstruction ✓

Date of onset

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

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) Fayette, (STATE OR COUNTRY) Mo.

FATHER 13. NAME Spencer McCrary

14. BIRTHPLACE (CITY OR TOWN) Fayette, (STATE OR COUNTRY) Mo.

Name of operation Laparotomy Date of 8/9/39

What test confirmed diagnosis Operation Was there an autopsy? no

MOTHER 15. MAIDEN NAME Fanny Miller

16. BIRTHPLACE (CITY OR TOWN) Fayette, (STATE OR COUNTRY) Mo.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? 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.

17. INFORMANT Mrs. Mary McCrary (ADDRESS) Fayette, Mo.

Manner of injury

Signature of injury

18. BURIAL, CREMATION, OR REMOVAL PLACE Fayette, Mo. DATE 8/17, 1939

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

19. FUNERAL DIRECTOR (NAME) Guy T. Halley (ADDRESS) Fayette, Mo.

(Signed) H. Hogan, M. D.

20. FILED 8-16-, 1939 Uida W. SIMONS Local Registrar.

(Address) West Plains, Mo.

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.

District Health Officer No. 5,

District File Number 1039 257

Date Filed 10239

Signed _____

Licensed Embalmer No. _____

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32529 7
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1. PLACE OF DEATH

(a) County Howell Registration District No. 384
(b) Township _____ Primary Registration District No. 4227 Registered No. _____
(c) City West Plains (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 Everett McCrory

(a) Residence, No. _____ St. 1
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 7 3

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-15, 1959

22. I HEREBY CERTIFY, That I attended deceased from _____ 1959 to _____ 1959

I last saw h. _____ alive on _____, 1959. 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:

Intestinal Obstruction
Caused by intestinal Adhesions

Detail exact

Other contributory causes of importance:

Name of operation _____ 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? _____ Date of injury _____, 1959

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? _____

If so, specify _____

(Signed) R. E. Hogan, M. D.

(Address) West Plains Mo.

RECORDED BY LAW.

CERTIFICATES UNTIL THEY

REGISTRARS SH U L N I R I E A

Do not use this space.

STATE BOARD OF HEALTH
OFFICE OF VITAL STATISTICS
STATE OF CALIFORNIA

Registered No. _____

in U.S., if of foreign birth; give year, month, day, and hour of birth, and name of hospital, institution, write its name in full of street and number, city, county, and state.

Place of birth (city or town and State)

OF DEATH

_____ 19__

and deceased from

_____ 19__

his said