

STANDARD CERTIFICATE OF DEATH

Registration District No. 147

Primary Registration District No. 5310

Registrar's No.

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural Austin Twp. 7
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 2 yr.
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cass
(c) City or town Rural Harrisonville
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME BENJAMIN FRANKLIN McCoy

8. (b) If veteran, name war. 8. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bessie McCoy 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased (Month) Feb (Day) 20 (Year) 1890

8. AGE: Years 50 Months 7 Days 10 If less than one day hr. min.

9. Birthplace Louisburg Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer - W.O.A.

11. Industry or business _____

MOTHER FATHER { 12. Name John McCoy

13. Birthplace Louisburg Kansas
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Morgan

15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Resident L. McCoy

(b) Address Austin Mo.

17. (a) burial (b) Date thereof Apr 30 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friend Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO

19. (a) 10-4-40 (Date received local registrar) (b) Mrs. Doris Gibson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1940 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from 4.21.39
_____ 19____ to 9.30 1940
that I last saw him alive on 9.29 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerosis Duration 1 mo

Due to Acute Insufficiency (non Apneic)

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

140 (Specify type of place) (e) Means of injury _____

23. Signature Fred Under MD (M. D. or other) _____

Address Harrisonville, Mo Date signed 9/30/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Ernest Rummelburger

Licensed Embalmer No. _____

3368

P. O. Address _____

Harrisonville Mo

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.