

FILED NOV 8 1944

Registration District No. 72

Primary Registration District No. 1600

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution State Hospital No 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo 5 da.
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Independence
(If outside city or town limits, write "RURAL.")

(d) Street No. 1321 Sterling
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0 7
If yes, name country _____

3. (a) PRINT FULL NAME ROBERT LEE McCARY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Margaret McCary 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 10 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 14 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Albion, Mo (City, town, or county) U I (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Benjamin McCary

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

14. Maiden name Roxey Ann Magee

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

16. (a) Informant Record Hospital

(b) Address St Joseph Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 24 44
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director George M. Collier

(b) Address 1103 Wynnard St. Jdco Mo.

19. (a) 10-24-44 (Date received local registrar) (b) Delores Cochle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24
year 1944 hour 12-30 minute a M.

21. I hereby certify that I attended the deceased from 10-20, 1944 to 10-20, 1944
that I last saw him alive on 10-23, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia
Bacterial

Due to Arteriosclerosis & general debility

Due to _____

Other conditions Senile Deterioration
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G.E. Salzer (M. D. or other) _____
Address St Joseph Mo. Date signed _____

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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.....

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, fact should be so stated above.