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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9933

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 36

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Webb City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jane Chinn Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Oronogo (If outside city or town limits, write "RURAL") 0
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Beecher Q McCoy
3. (b) If veteran, name war
3. (c) Social Security No. 078-05-1120
4. Sex Male 1
5. Color or race White
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or wife Letha McCoy
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased May (Month) 1 (Day) 1881 (Year)

8. AGE: Years	Months	Days	If less than one day
63	10	18	hr. min.

9. Birthplace Harrison (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Miner
11. Industry or business
FATHER
12. Name James M. McCoy
13. Birthplace Quincy (City, town, or county) Ill 1 (State or foreign country)
MOTHER
14. Maiden name Susan Braswell
15. Birthplace (City, town, or county) Ark 1 (State or foreign country)
16. (a) Informant Letha McCoy
(b) Address Oronogo Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 20 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Oronogo Cem
18. (a) Signature of funeral director Webb City Und Co
(b) Address Webb City Mo
19. (a) Mar. 20 1945 (Date received local registrar) (b) Mrs. Lillie Lagle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18 year 1945 hour 4 minute a. M.
21. I hereby certify that I attended the deceased from 3-13, 1945, to 3-18, 1945; that I last saw him alive on 3-18, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia of Flu type	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 33 a	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature M S Slaughter M.D. (Name or other)
Address Webb City Mo Date signed 3/20/45

11 5 a (Licensed Embalmer's Statement on Reverse Side)

45-3-281

FEB 17 1955

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

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City 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, fact should be so stated above.