

FILED APR 29 1946

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Cass  
(b) City or town Harrisonville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Quincy Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
Specify whether  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County Cass 19  
(c) City or town Harrisonville MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

James L McCulloch

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 18 1946  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 hr. min.

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

10. Usual occupation none

11. Industry or business

12. Name R B McCulloch  
13. Birthplace MO (City, town, or county) (State or foreign country)  
14. Maiden name Catherine Coy  
15. Birthplace MO (City, town, or county) (State or foreign country)

16. (a) Informant R B McCulloch

(b) Address Harrisonville City

(a) Burial (b) Date thereof 4 20 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quincy City

18. (a) Signature of funeral director M. Kaufman

(b) Address Harrisonville MO

19. (a) April 20 46 (b) Laura Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th year 1946 hour 10 minute 30 AM.

21. I hereby certify that I attended the deceased from 4/18th 1946, to 4/19 1946 that I last saw him alive on 4/19 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (7 1/2 months)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: none  
(Include pregnancy within 3 months of death)

Major findings: none  
Of operations none  
Of autopsy none

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? Quincy City (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) (c) Means of injury 2

23. Signature Dr. St. Oliver (M. D. or other) DO  
Address Harrisonville MO Date signed 4/19-46

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

9

1

0

11431

**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

*J. W. Kaufman*

Licensed Embalmer No.

*1020*

P. O. Address

*Garden City*

**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.**