

FILED AUG 23 1946

STANDARD CERTIFICATE OF DEATH

27757

State File No.

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 277

1. PLACE OF DEATH: Marian

(a) County Marian Co

(b) City or town Hannibal Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Levering Hospital
(If not in hospital or institution, state street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME EVALENA-MABLE-McKAY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

(b) Name of husband John Victor McKay 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: John 6 1863
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Shelby Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Says Hewitt

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

14. Maiden name Marion Jane Fear

15. Birthplace Morgan Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant J. McKay Jr.
(b) Address Knox City Mo

17. (a) Removal (b) Date thereof 8-10-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Knox City Mo

18. (a) Signature of funeral director Ray P. Schwartz
(b) Address Hannibal Mo
19. (a) 8-19-46 (b) Dr. E.M. Lucke
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Knox 52

(c) City or town Knox City 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 1

(e) If foreign born, how long in U. S. A.? 12 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9
year 1946 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 6, 1946, to Aug 19, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Diabetes mellitus 5 yrs

Due to Acute cholelithiasis and hepatitis 1 wk

Due to Diabetic coma 3d

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

Major findings: _____ Of operations _____ Of autopsy W

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 Howard B. Sudeed (M. D. or other) MD
Address Hannibal, Mo Date signed 8/19/46

Duration
<u>5 yrs</u>
<u>1 wk</u>
<u>3d</u>

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

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

MOTHER FATHER

CONFIDENTIAL

MAXINE-BRAM-BUSBY

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 *Paul Richard Brown*

Licensed Embalmer No. *4324*

P. O. Address *1000 Broadway
Humboldt, Ind.*

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.