

S. No. 2  
DM-5-42  
Rev. 5-17-39.  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5404

FILED FEB 17 1947

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

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Chillicothe, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Chillicothe Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 hrs 30 min  
(Specify whether years, months or days)  
In this community 7 hrs 30 min

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston  
(c) City or town Chillicothe  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1531 Bryan  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Allan McCoy

3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Male 5. Color or race W  
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 1 - 31 - '47  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 7 hr. 30 min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Charles Green McCoy

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

14. Maiden name Geneva Harraine Schuler

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

16. (a) Informant Charles G. McCoy  
(b) Address Chillicothe, Missouri

17. (a) Removal (b) Date thereof 2-2-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Norman Funeral Home  
(b) Address Chillicothe, Missouri

19. (a) Feb - 2 - 47 (b) James B. Neill  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1  
year 1947 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from birth  
Jan 31 1947 to Feb 1 1947  
that I last saw him alive on Feb 1 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 15-9

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)  
(c) Means of injury ( )

23. Signature Joseph F. Galt (M. D. or other) MD  
Address Chillicothe Mo Date signed Feb 1-47

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

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

galt

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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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 Elton J. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri.

**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.**