

S. No. 2
M-1/47
7-5-17-39

U.S. DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23368**
Registrar's No. **186**

FILED JUL 17 1947

Registration District No. **38**

Primary Registration District No. **3006**

10
2
4

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

1. PLACE OF DEATH:

(a) County **Boone**

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

(c) Name of hospital or institution **Boone County Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 Hours**
(Specify whether years, months or days)

In this community **8 Hours**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone**

(c) City or town **Columbia**
(If outside city or town limits, write "RURAL")

(d) Street No. **510 Fairway Village**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME **KATHLEEN LOUISE McCRADY**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **11**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased **7 - 3 - 1947**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	0	8 hr. min.

9. Birthplace **Columbia Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Raymond McCrady**

13. Birthplace **Augusta Arkansas**
(City, town, or county) (State or foreign country)

14. Maiden name **Myrtice Lenore Mortenson**

15. Birthplace **Minneapolis Minnesota**
(City, town, or county) (State or foreign country)

16. (a) Informant **Raymond McCrady**

(b) Address **510 Fairway Village, Columbia, Mo.**

17. (a) Burial **Burial** **(b) Date thereof** **7-4-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Columbia Cemetery**

18. (a) Signature of funeral director **Parker Funeral Service**
(b) Address **Columbia, Mo.**

19. (a) 7-8-46 **(b) Mrs. R. E. Palmer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **3** year **1947** hour **6** minute **P. M.**

21. I hereby certify that I attended the deceased from **July 3, 1947**
10:00 A.M. 19 to **July 3, 1947**
6:00 P.M.

that I last saw her alive on **July 3, 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary atelectasis**
Prematurity

Due to **Prematurity**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **159**

Of operations

Of autopsy

PHYSICIAN

Underline the cause of 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? (Specify type of place)

(e) Means of injury

23. Signature **James M. Baker** (M. D. or other)

Columbia, Mo. Date signed **July 7, 1947**

Date Filed 7-16-47

District File Number _____

District Health Officer No. 9,

RECEIVED

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 M. N. Whitesides

Licensed Embalmer No. 3893

P. O. Address Columbia 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.