

1/47
5-17-39

FILED SEP 8 1948

Registration District No. **155**

Primary Registration District No. **5580**

Registrar's No. **137**

1. PLACE OF DEATH:

(a) County **Jasper**

(b) City or town **Carl Junction, Mo.**
(If outside city or town limits, write "RURAL" and "TOWNSHIP")

(c) Name of hospital or institution: **Twin Groves**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **72** years, months or days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jasper**

(c) City or town **Rural - TWIN GROVES TWP.**
(If outside city or town limits, write "RURAL")

(d) Street No. **1 mi West Carl Jct.**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Frederick Grant McCoy**

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

name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **29** year **1948** hour **3** minute **30 A.M.**

4. Sex **MO** 5. Color or race **W**

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

6. (b) Name of husband or wife **Genevieve McCoy** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **Nov 15 1870**
(Month) (Day) (Year)

I hereby certify that I attended the deceased from **June 4 1948** to **Aug 28 1948** that I last saw him **alive on Aug 28 1948** and that death occurred on the date and hour stated above.

8. AGE: Years **77** Months **9** Days **14** If less than one day _____ hr. _____ min.

Immediate cause of death: **Chronic Coronary Arteriosclerosis**

Due to _____

9. Birthplace: **Iola Mo.** (City, town, or county) **Ks.** (State or foreign country)

Other conditions: **Hypertension 1 yr**

(Include pregnancy within 3 months of death)

10. Usual occupation **Merchant**

Major findings: **1310**

Of operations _____

11. Industry or business **grocery**

Of autopsy _____

12. Name **John P. McCoy**

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

14. Maiden name **Margaretta Hodgland**

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

16. (a) Informant **J. P. McCoy**

(b) Address **Carl Junction, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date there of: **8-31-1948** (Month) (Day) (Year)

(c) Place: burial or cremation **Funeral Home**

18. (a) Signature of funeral director **Don Honey**

(b) Address **Carl Junction, Mo.**

19. (a) **AUG 30 1948** (Date received local registrar)

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 **C. L. Albert** (Name or other) _____

Address **Carl Junction, Mo.** Date signed **Aug 30 1948**

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

9
0
0

MOTHER FATHER

James M. Johnston
4304
Webb City, Mo

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 *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.