

FILED JAN 4 1949

Registration District No. 64

Primary Registration District No. 4110

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Chariton

(b) City or town Salisbury

(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

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

In this community Life \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William James McCurry

3. (b) If veteran, ✓ name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12 year 1948 hour 5 minute A.M.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Dolly 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Sept 17 1872  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 11 1948 to December 12 1948 that I last saw him alive on December 11 1948 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>2</u>	<u>25</u>	hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage Duration 11 hours

Due to Hypertension & arteriosclerosis ?

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

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

10. Usual occupation Retired mail carrier

Other conditions Bilateral glaucoma - chronic 20 yrs.  
(Include pregnancy within 3 months of death)

MOTHER FATHER

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

12. Name George Porter McCurry

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

14. Maiden name Eunice Thurston

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

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Dolly McCurry

(b) Address Salisbury

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-48  
(Month) (Day) (Year)

(c) Place: burial or cremation Salisbury Cemetery

18. (a) Signature of funeral director G. B. White

(b) Address Salisbury Mo

19. (a) 12-15-48 (Date received local registrar) (b) G. B. White (Registrar's signature)

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) (a) Means of injury \_\_\_\_\_

23. Signature J. L. Harris (M. D. or other) MD

Address Salisbury Mo Date signed 12-14-48

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

RECEIVED

District Health Officer No. 8

District File No. \_\_\_\_\_

Date Filed 1-B-49

350  
10/10/49

JAN 7 1949

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 *Chas B Winkelmeyer*

Licensed Embalmer No. 3842

P. O. Address Salisbury

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.