

FILED OCT 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35917

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6876 Registrar's No. 411

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Indiana b. COUNTY Warwick	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jefferson Barracks, Mo. 24 day		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Newburgh	
d. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		d. STREET ADDRESS (If rural, give location) Route 3	

3. NAME OF DECEASED (Type or Print) a. (First) MARION	b. (Middle) R.	c. (Last) MC COWN	4. DATE OF DEATH (Month) (Day) (Year) 10/9/49
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1/30/12	9. AGE (In years last birthday) 37	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Spottsville, Ky.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Leslie M. McCown	13b. MOTHER'S MAIDEN NAME Sally McKinley	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World II	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT'S SIGNATURE OR NAME V. A. HOSPITAL RECORDS	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Unk.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHOGENIC CARCINOMA OF LUNG		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		163 X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) V.A.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 9/16, 1949, to 10/9, 1949, and that death occurred at 9:45a m., from the causes and on the date stated above.

23a. SIGNATURE L. E. Stillwell (Degree or title) M.D., Chf. of Prof. Services	23b. ADDRESS V.A. HOSP. JEFF. BRKS. MO.	23c. DATE SIGNED 10-10-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-10-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Newburgh, Ind.
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DATE REC'D BY LOCAL REG. 10-10-49	REGISTRAR'S SIGNATURE Herbert R. Donke, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 14 1949

DEC 2 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Albert G. Hoppe*

Licensed Embalmer No. *2971*

P. O. Address _____

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.