

FILED MAY 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14024
State File No.

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 160

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>	
c. LENGTH OF STAY (In this place) <u>6 mo.</u>		d. STREET ADDRESS (If rural, give location) <u>117 1/2 E. Broadway</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>			
3. NAME OF DECEASED a. (First) <u>EMMA</u> (Type or Print)		b. (Middle) _____ c. (Last) <u>McCurdy</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>April 16 1950</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Jan. 8 - 1866</u>	
9. AGE (In years last birthday) <u>84</u>		10. IF UNDER 1 YEAR Days <u>8</u> IF UNDER 1 HR. Hours <u>8</u> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Warsaw Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13a. FATHER'S NAME <u>Oliver Elmore</u>		13b. MOTHER'S MAIDEN NAME <u>Sallie Payne</u>	
14. NAME OF HUSBAND OR WIFE <u>James H. McCurdy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Robert McCurdy</u>		RURAL ADDRESS <u>Sedalia</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocarditis, chronic</u> ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>anemia, pernicious arthritis, hypotension</u>	
INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Aug 2, 1949</u> , to <u>April 16, 1950</u> , that I last saw the deceased alive on <u>April 16, 1950</u> , and that death occurred at <u>10:50 A. M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Chas. Gordon Stauffer MD</u>		23b. ADDRESS <u>Sedalia Mo</u>	
23c. DATE SIGNED <u>4-17-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-18-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>	
DATE REC'D BY LOCAL REG. <u>4-18-50</u>		REGISTRAR'S SIGNATURE <u>R. G. Campbell M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>M. Laughlin Bros</u>		ADDRESS <u>Sedalia</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

804

RECEIVED APR 27

District Health Officer No. 8.

District File Number

Date Filed 5/3/50

AUG 29 1951

SEP 12 1951

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 K.P.M. Gray
Licensed Embalmer No. 3153

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.