

No. 300  
10. 48

FILED SEP 19 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29843

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 94

1. PLACE OF DEATH a. COUNTY <b>Cooper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Boonville</b>		c. LENGTH OF STAY (in this place) <b>1 Day</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City,</b> <b>3008</b>	
		d. STREET ADDRESS (If rural, give location) <b>??</b> <b>1</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Mary</b>	b. (Middle) <b>Ann</b>	c. (Last) <b>McAlester</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>September 15 1950</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>June 5<sup>th</sup> 1931</b>	9. AGE (In years last birthday) <b>19</b>	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) <b>at home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Kansas City, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Dr. A. W. McAlester III</b>	13b. MOTHER'S MAIDEN NAME <b>Sallie Adele Pendleton</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Dr. A. W. McAlester, Kansas City, Mo.</b>	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  <b>608 16<sup>h</sup> 26<sup>m}</sup></b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Compound skull fracture</b>		
	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. <b>Fracture Right femur</b>			

19a. DATE OF OPERATION <b>9-14-50</b>	19b. MAJOR FINDINGS OF OPERATION <b>Compound skull fracture</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>U.S. Highway 40</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>RFD Cooper MO</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>9-14-50 4:45 P.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>wrecking of motor car</b>
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22. I hereby certify that I attended the deceased from **9-14**, 19**50**, to **9-15**, 19**50**, that I last saw the deceased alive on **9-15**, 19**50**, and that death occurred at **11:30 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J. C. Beckett M.D.</b>	23b. ADDRESS <b>Boonville Mo</b>	23c. DATE SIGNED <b>9-15-50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept. 18 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>????</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri.</b>
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DATE REC'D BY LOCAL REG. <b>9-15-50</b>	REGISTRAR'S SIGNATURE <b>D. Hooper</b> <b>381</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Goodman &amp; Boller, Boonville, Missouri.</b>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 9-18-50

DISTRICT HEALTH OFFICE No. 3

District File Number

Date Filed 9-18-50

NOV 28 1950

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

working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed *J. H. Goodman*

Licensed Embalmer No. 1178

P. O. Address *Roanoke, Va.*

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.