

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10090**

FILED DEC 19 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **3-59** PRIMARY REG. DIST. NO. **4097** Registrar's No. **187**

1. PLACE OF DEATH  
a. COUNTY **Cass**  
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Harrisonville**  
c. LENGTH OF STAY (in this place) **60 yrs**  
d. FULL NAME OF HOSPITAL OR INSTITUTION **At home**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE **Mo**  
b. COUNTY **Cass**  
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Harrisonville**  
d. STREET ADDRESS (If rural, give location) **506 West Pearl.**

3. NAME OF DECEASED  
a. (First) **Frank**  
b. (Middle) **—**  
c. (Last) **May**  
4. DATE OF DEATH (Month) (Day) (Year) **Dec. 9-1950**

5. SEX **Male**  
6. COLOR OF RACE **White**  
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**  
8. DATE OF BIRTH **Aug 10-1879**  
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min. **72 3 29**

10a. USUAL OCCUPATION (Give kind of work and specify months of working life, if not retired) **City Mail Carrier**  
10b. KIND OF BUSINESS OR INDUSTRY **Retired**  
11. BIRTHPLACE (State or foreign country) **Berlin, Ky.**  
12. CITIZENSHIP OF WHAT COUNTRY **USA.**

13. FATHER'S NAME **John W. May**  
13b. MOTHER'S MAIDEN NAME **Maggie Bottom**  
14. NAME OF DECEASED OR WIFE **Maudie A May**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of dates of service) **No**  
16. SOCIAL SECURITY NO. **None**  
17. INFORMANT'S SIGNATURE OR NAME **Mrs May Harrisonville** ADDRESS **Cass**

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **PHLECYSTIS**  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) **RECURRENT ARTHRITIS**  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death. **SENILITY**

INTERVAL BETWEEN ONSET AND DEATH **725X**

19a. DATE OF OPERATION \_\_\_\_\_  
19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_  
20. AUTOPSY? YES  NO

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) (Minute) \_\_\_\_\_  
21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  \_\_\_\_\_  
21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from **12-9-50** to **12-9-50**, that I last saw the deceased alive on **12-9-50**, and that death occurred at **12:00** m., from the causes and on the date stated above.

23a. SIGNATURE **Donald Long MD** (Degree or title)  
23b. ADDRESS **Harrisonville Mo**  
23c. DATE SIGNED **12/11/50**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**  
24b. DATE **Dec 11-50**  
24c. NAME OF CEMETERY OR CREMATORY **Oakland Cen.**  
24d. LOCATION (City, town, or county) (State) **Harrisonville Mo**

DATE REC'D BY LOCAL REG. **Dec. 11, 1950**  
REGISTRAR'S SIGNATURE **Laura J. Jones**  
25. FUNERAL DIRECTOR'S SIGNATURE **William B. ...** ADDRESS **Harrisonville Mo**

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

0190  
1

RECEIVED  
DEC 16 1950  
Grand County  
HEALTH DEPARTMENT

DEC 21 1950

JAN 9 1951

1951

JAN 8 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.....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No.....  
Signed *Walter W. Johnson*

Licensed Embalmer No. 3990

P. O. Address *Harrisville*

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.

*Me*