

JUN 9 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15475

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>1</u>	PRIMARY REG. DIST. NO. <u>3000</u>	Registrar's No. <u>209</u>
1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Iowa</u> b. COUNTY <u>Vernon</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (in this place) <u>4 Days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Stockport</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>Stockport, Iowa</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Fayette</u> c. (Last) <u>McKee</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 2, 1952</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 22, 1903</u>	9. AGE (In years last birthday) <u>49</u> If under 1 year: Months _____ Days _____ If under 12 mos. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Co-owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Locker Plant</u>	11. BIRTHPLACE (State or foreign country) <u>Jefferson Co., Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>George McKee</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Grant</u>	14. NAME OF HUSBAND OR WIFE <u>Meda Mae McKee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War 2</u>		16. SOCIAL SECURITY NO. ....	17. INFORMANT'S SIGNATURE OR NAME <u>Meda McKee</u> ADDRESS <u>Stockport, Iowa</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Phyrotuberculosis</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>25 minutes</u>  <u>several years</u>  <u>several years</u>
19a. DATE OF OPERATION <u>5-29-52</u>		19b. MAJOR FINDINGS OF OPERATION <u>Large intrathoracic gaster</u>		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) (m.)		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>5-29-52</u> , 19 <u>52</u> , to <u>6-2-52</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>6-1-52</u> , 19 <u>52</u> , and that death occurred at <u>1:00 AM</u> m., from the causes and on the date stated above.				
23a. SIGNATURE <u>G. Stucky, D.O.</u> (Degree or title)		23b. ADDRESS <u>Kirksville, Mo.</u>		23c. DATE SIGNED <u>6-2-52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/4/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Spencer Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Stockport, Iowa</u>	
DATE REC'D BY LOCAL REG. <u>6-7-52</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bohner, Fairfield, Ia</u>		ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

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JUN 1 1958

**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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Fiskville, Mo.

**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.