

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 12 1953

BIRTH NO. _____ REG. DIST. NO. **251** PRIMARY REG. DIST. NO. **3048** Registrar's No. **6**

742
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY NODAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY NODAWAY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MARYVILLE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BURLINGTON JCT. MO	
c. LENGTH OF STAY (In this place) 3 day		d. STREET ADDRESS (If rural, give location) 0740	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST FRANCIS HOSP			

3. NAME OF DECEASED (Type or Print) a. (First) ELI b. (Middle) ALBERT c. (Last) MCATEE			4. DATE OF DEATH (Month) (Day) (Year) JAN 3 1953		
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH MCH. 25, 1868		9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months 9 Days 6 IF UNDER 6 MOS. Weeks _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MERCER COUNTY, MO	
12. CITIZEN OF WHAT COUNTRY? US					

13a. FATHER'S NAME SAMUEL ALBERT MCATEE		13b. MOTHER'S MAIDEN NAME MARY ANN PRUITT		14. NAME OF HUSBAND OR WIFE ALICE F. TIBBETTS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME MRS. BLANCHE MILLER ADDRESS BURL. JCT. MO	

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.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bladder hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Prostate hypertrophy		2. _____	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3. _____	

18a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 610X		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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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) _____	
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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? _____	
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22. I hereby certify that I attended the deceased from **Jan. 1, 1953**, to **Jan. 3, 1953**, that I last saw the deceased alive on **Jan. 3, 1953**, and that death occurred at **11:35 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE B. A. Bryant (Degree or title) _____		23b. ADDRESS Maryville Mo		23c. DATE SIGNED 1-7-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 1-6-1953		24c. NAME OF CEMETERY OR CREMATORY OHIO	
24d. LOCATION (City, town, or county) (State) BURLINGTON JCT MO					

DATE REC'D BY LOCAL REG. 1-10-53		REGISTRAR'S SIGNATURE Bess Bolt		25. FUNERAL DIRECTOR'S SIGNATURE J. H. Hahn ADDRESS BURLINGTON JCT MO	
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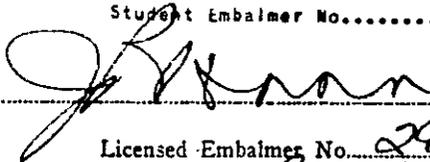
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No. 2967

P. O. Address Burr. Ind. Mo

Signed.....
Student Embalmer

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.