

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6103**
Registrar's No. **987**

FILED MAR 13 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY <u>Jackson County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City, Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Adrian</u>	
c. LENGTH OF STAY (If in this place) <u>9 days</u>		d. STREET ADDRESS (If rural, give location) <u>CO70, X</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>William</u>	b. (Middle) <u>N.</u>	c. (Last) <u>Mc Coy</u>	4. DATE OF DEATH (Month) (Day) (Year)	<u>Feb.</u> <u>12</u> <u>1953</u>
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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>June 13, 1875</u>	9. AGE (In years) (last birthday) <u>77</u>	if UNDER 1 YEAR Months <u>7</u> Days <u>29</u>	if UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS* OR INDUSTRY <u></u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Archie Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>Yes U.S.</u>
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13a. FATHER'S NAME <u>George Dallas McCoy</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Cook</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Marie McCoy</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>499-09-4177</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Marie McCoy, Adrian Mo.</u>	ADDRESS <u></u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anuria - Uremia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Postoperative Prostatic Surgery</u> DUE TO (c) <u>Prostatic Hypertrophy</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>		610X	

19a. DATE OF OPERATION <u>2-5-53</u>	19b. MAJOR FINDINGS OF OPERATION <u>Prostatic Hypertrophy - Benign</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u></u>	21b. PLACE OF INJURY (e.g. home or about home, farm, factory, street, office bldg., etc.) <u></u>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u></u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u></u>
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22. I hereby certify that I attended the deceased from February 3, 1953, to February 12, 1953, that I last saw the deceased alive on February 12, 1953, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Gra T. Smith</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>1019 Professional Bldg, Kansas City 6 Mo.</u>	23c. DATE SIGNED <u>2/13/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2-12-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crescent Hill Cemetery Adrian Mo.</u>	24d. LOCATION (City, town, or county) (State) <u></u>
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DATE REC'D BY LOCAL REG. <u>2-16-53</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Prof. Funeral Service, Adrian Mo.</u>	ADDRESS <u></u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Licensed Embalmer No. 3650

P. O. Address Adrian Ma

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.