

FILED FEB 28 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8588

BIRTH NO. _____ REG. DIST. NO. 373 PRIMARY REG. DIST. NO. 6265 Registrar's No. 19

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

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURALS. GRANT		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL S. GRANT	
c. LENGTH OF STAY (in this place) 10 YRS		d. STREET ADDRESS (If rural, give location) 1120	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) MCKAY c. (Last) MCKAY			4. DATE OF DEATH (Month) (Day) (Year) FEB 21 1953		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH MAR 15 1875		9. AGE (In years last birthday) 77		10. MONTHS 11 DAYS 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) FT. SCOTT KANS	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE MARY MCKAY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME JENNIE GREEN STRAFFORD		18. ADDRESS RI			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory Failure		DUPLICATE OF (b) Medullary Paralysis			DUPLICATE OF (c) Status Epilepticus
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (b) of unknown cause			24hr
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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 **6/15, 1952**, to **2/21, 1953**, that I last saw the deceased alive on **2/21, 1953**, and that death occurred at **10 Am.**, from the causes and on the date stated above.

23a. SIGNATURE <i>J. P. Blum</i> (Degree or title) D.O.		23b. ADDRESS Manassas, Mo.		23c. DATE SIGNED 2/23/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2-23-53		24c. NAME OF CEMETERY OR CREMATORY BASSVILLE	
24d. LOCATION (City, town, or county) (State) GREENE CO MO		24e. FUNERAL DIRECTOR'S SIGNATURE BARBER BARTO		24f. ADDRESS MARSHFIELD	

DATE REC'D BY LOCAL REG. **2/23/53**

REGISTRAR'S SIGNATURE *J. P. Blum* **392**

25. FUNERAL DIRECTOR'S SIGNATURE **BARBER BARTO** ADDRESS **MARSHFIELD**

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 R. W. Barber

Licensed Embalmer No. 3848

P. O. Address 711 1/2 Ave

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.