

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **31622**

FILED OCT 13 1953

BIRTH NO. _____ REG. DIST. NO. **138** PRIMARY REG. DIST. NO. **5321** Registrar's No. **40**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY He. Kory		a. STATE Missouri b. COUNTY Hickory	
b. CITY, (If outside corporate limits, write RURAL and give township) OR TOWN Hermitage		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hermitage	
c. LENGTH OF STAY (in this place) 40 years		d. STREET ADDRESS (If rural, give location) South of Square	
d. FULL NAME OF HOSPITAL OR INSTITUTION South of Square			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Charles	b. (Middle) Luther	c. (Last) McCain	Oct. 6-1953		

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 11-1885	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 11 Days 23	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	11. BIRTHPLACE (State or foreign country) Preston Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry McCain	13b. MOTHER'S MAIDEN NAME Sarah Curdell	14. NAME OF HUSBAND OR WIFE Dorace McCain
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or date of service) None	17. INFORMANT'S SIGNATURE OR NAME. Dorace McCain - Hermitage, Mo	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	PRECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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"/>
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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 Oct 6, 1953, to Oct 6, 1953, that I last saw the deceased alive on Oct 6, 1953, and that death occurred at 9:29 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Al Navarro M.D.	23b. ADDRESS Hermitage Mo	23c. DATE SIGNED 10-5-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-8-53	24c. NAME OF CEMETERY OR CREMATORY Hermitage Cemetery	24d. LOCATION (City, town, or county) (State) Hermitage Mo
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DATE REC'D BY LOCAL REG. 10-8-53	REGISTRAR'S SIGNATURE Mary Johnson	464	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hawley	ADDRESS Hermitage Mo
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

S. No. 300
V. 10.48

OCT 15 1982

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 Chas. Siller Hathaway

Licensed Embalmer No. 4267

P. O. Address Wheatland, Md

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.

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