

No. 300  
10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44847

State File No. ....

FILED DEC 21 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3071 Registrar's No. 39

1. PLACE OF DEATH  
a. COUNTY Saline 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Mo b. COUNTY Saline

b. CITY (If outside corporate limits, write RURAL and give township) Slater c. LENGTH OF STAY (If in institution) 5 months c. CITY OR TOWN Slater d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Convalescent Home e. STREET ADDRESS (If rural, give location) 336 North Main Street

3. NAME OF DECEASED (First) (Middle) (Last) 4. DATE OF DEATH (Month) (Day) (Year)  
CHARLES McLAUGHLIN Dec-12-53

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 8. DATE OF BIRTH Nov 30-1892 9. AGE (In years last birthday) 61-10-12 IF UNDER 1 YEAR Months Days IF UNDER 18 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most preceding life, when if retired) Retired Farmer 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (City and State or Foreign Country) Wetzel County, Mo 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Will McLaughlin 13b. MOTHER'S MAIDEN NAME Mary Nichols 14. NAME OF HUSBAND OR WIFE \_\_\_\_\_

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Lee McLaughlin, Woodruff, Ill ADDRESS \_\_\_\_\_

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.  
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Chronic Myocarditis INTERVAL BETWEEN ONSET AND DEATH 5 years  
ANTECEDENT CAUSES failure 10 days  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) Generalized Atherosclerosis years  
11. OTHER SIGNIFICANT CONDITIONS Virus Infection - U.R.I 2 wk previous  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION 4-2-21 19c. AUTOPSY? YES  NO

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) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from June 12, 1953, to Dec. 12, 1953, that I last saw the deceased alive on Dec. 11, 1953 and that death occurred at 6 P m., from the causes and on the date stated above.

23a. SIGNATURE C. A. McBurney, M.D. (Degree or title) 23b. ADDRESS Slater, Mo. 23c. DATE SIGNED 12/15/53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 12-15-53 24c. NAME OF CEMETERY OR CREMATORY City Cemetery 24d. LOCATION (City, town, or county) (State) Slater Mo

DATE REC'D BY LOCAL REG. 12/15/53 REGISTRAR'S SIGNATURE Mrs. Earl C. Mize 25. FUNERAL DIRECTOR'S SIGNATURE J. Jones ADDRESS Slater, Mo

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

09714

DEC 23 1953

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  Signature of Student Embalmer

Signed *James E. Jones* Licensed Embalmer No. *319*  
P. O. Address *States*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.