

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4064

State File No. ....

FILED FEB 23 1954

BIRTH NO. .... REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 178

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Buchanan |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 3309 Sacramento St.                             |  | d. STREET ADDRESS (If rural, give location) 3309 Sacramento St.  |  |

|  |            |             |                 |                                    |                      |
|--|------------|-------------|-----------------|------------------------------------|----------------------|
| 3. NAME OF DECEASED (Type or Print) Bessie | a. (First) | b. (Middle) | c. (Last) McCoy | 4. DATE OF DEATH February 16, 1954 | (Month) (Day) (Year) |
|--|------------|-------------|-----------------|------------------------------------|----------------------|

|               |                        |  |                                 |                                    |                        |                       |                        |                       |
|---------------|------------------------|--|---------------------------------|------------------------------------|------------------------|-----------------------|------------------------|-----------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married | 8. DATE OF BIRTH June 18, 1877. | 9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR Months | IF UNDER 12 HRS. Days | IF UNDER 12 HRS. Hours | IF UNDER 12 HRS. Min. |
|---------------|------------------------|--|---------------------------------|------------------------------------|------------------------|-----------------------|------------------------|-----------------------|

|  |  |   |                                  |
|--|--|---|----------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Librarian | 10b. KIND OF BUSINESS OR INDUSTRY Public Library | 11. BIRTHPLACE (State or foreign country) Golconda, Illinois. | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|--|---|----------------------------------|

|                                     |  |                                  |
|-------------------------------------|--|----------------------------------|
| 13a. FATHER'S NAME Charles R. McCoy | 13b. MOTHER'S MAIDEN NAME Julia Robinson | 14. NAME OF HUSBAND OR WIFE None |
|-------------------------------------|--|----------------------------------|

|  |                              |  |                         |
|--|------------------------------|--|-------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Miss. Blanche L. Schrick | ADDRESS St. Joseph, Mo. |
|--|------------------------------|--|-------------------------|

|   |   |   |  |
|---|---|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |   | INTERVAL BETWEEN ONSET AND DEATH<br>2 days |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobor Pneumonia  |   |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |   |  |
| II. OTHER SIGNIFICANT CONDITIONS - Severe arteriosclerosis  |   | Conditions contributing to the death but not related to the disease or condition causing death. |  |

|                        |                                       |  |
|------------------------|---------------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 490X | 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) (Min.) | 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 March 18<sup>th</sup> 1954, to 2/16, 1954, that I last saw the deceased alive on 2/16, 1954, and that death occurred at 4:20 P.m., from the causes and on the date stated above.

|                                      |                              |                          |
|--------------------------------------|------------------------------|--------------------------|
| 23a. SIGNATURE Scott C. Benson, M.D. | 23b. ADDRESS 510 Cosby Beach | 23c. DATE SIGNED 2/17/54 |
|--------------------------------------|------------------------------|--------------------------|

|  |                         |   |   |
|--|-------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Feb. 20, 1954 | 24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | 24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri. |
|--|-------------------------|---|---|

|                                       |   |  |                         |
|---------------------------------------|---|--|-------------------------|
| DATE REC'D BY LOCAL REG. Feb 18, 1954 | REGISTRAR'S SIGNATURE Thomas M. Allison | 25. FUNERAL DIRECTOR'S SIGNATURE Meyerhoffer Fleeman, Inc. | ADDRESS St. Joseph, Mo. |
|---------------------------------------|---|--|-------------------------|

(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

*Albert R. Harrington*

Licensed Embalmer No. 3258 Missouri.

P. O. Address St. Joseph, Missouri.

**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.