

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **4264**

FILED MAR 15 1954

BIRTH NO. _____ REG. DIST. NO. **57** PRIMARY REG. DIST. NO. **4093** Registrar's No. **36**

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

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Cass	
b. CITY OR TOWN East Lynne		c. CITY OR TOWN East Lynne	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS 2190	

3. NAME OF DECEASED (Type or Print) a. (First) CORA	b. (Middle) MAY	c. (Last) McCUE	4. DATE OF DEATH (Month) (Day) (Year) Mar 4 1954
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5. SEX Female	6. COLOR OF RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 28 1883	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) Madison Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Alfred Long	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Walter McCue
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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 dates of service) NONE	17. INFORMANT'S SIGNATURE OR NAME Jack Melcher	18. ADDRESS Harrisonville Missouri
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Sudden
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid 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. ESSENTIAL Hypertension			

19a. DATE OF OPERATION <input checked="" type="checkbox"/>	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 331X
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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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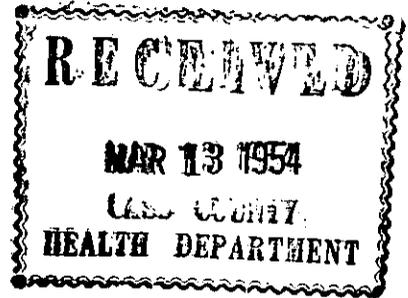
22. I hereby certify that I attended the deceased from **1948**, to **4 MAR 1954**, that I last saw the deceased alive on _____, 19____, and that death occurred at **5 A** m., from the causes and on the date stated above.

23a. SIGNATURE J. B. Barger MD	(Degree or title)	23b. ADDRESS Harrisonville Mo	23c. DATE SIGNED 5 MAR 54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar 6 1954	24c. NAME OF CEMETERY OR CREMATORY Strasburg Cemetery	24d. LOCATION (City, town, or county) (State) Strasburg Mo
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DATE REC'D BY LOCAL REG. Mar 6 1954	REGISTRAR'S SIGNATURE Dora Barriard	457-10	25. FUNERAL DIRECTOR'S SIGNATURE Penningsburg	ADDRESS Harrisonville Mo
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MAY 14 1954
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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 Ernest M. Ammerhues

Licensed Embalmer No. 3368

P. O. Address Harrisonville Mo

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.