

FILED JUN 14 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHDR. SHARPLESS
State File No. 15548

BIRTH NO.		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2002</u>		Registrar's No. <u>539</u>			
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> <u>CHRISTIAN</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>		c. LENGTH OF STAY (In hospital or institution) <u>1 WEEK</u>		c. CITY OR TOWN <u>OZARK</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN HOSP.</u>				e. STREET ADDRESS (If rural, give location) <u>STAR ROUTE</u> <u>0220</u> <u>1</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u>		b. (Middle) <u>PERRY</u>		c. (Last) <u>McCANN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 6 1954</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>AUG. 2 1880</u>			
9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M.D.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>JAMES McCANN</u>		13b. MOTHER'S MAIDEN NAME <u>MARIAH E. BOWLERS</u>		14. NAME OF HUSBAND OR WIFE <u>MARY McCANN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MARY McCANN OZARK, MO.</u>					
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>6 months many years.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>443X</u>							
21a. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u>9:10 P.M.</u>		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 <u>June 5, 1953</u> , to <u>June 6, 1954</u> , that I last saw the deceased alive on <u>6-6</u> , 19 <u>54</u> , and that death occurred at <u>9:10 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Type or Print) <u>James Marshall, M.D.</u>				23b. ADDRESS <u>Professional Bldg.</u>		23c. DATE SIGNED <u>6-7-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>6/9/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>WARRENSBURG CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>WARRENSBURG, MISSOURI</u>			
DATE REC'D BY LOCAL REG. <u>6-7-54</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. LOHMEYER SPRINGFIELD, MO.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 13 1961

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 *Walter E. Hamme*.....

Licensed Embalmer No....3808

P. O. Address....SPRINGFIELD

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.