

FILED MAR 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7947

BIRTH NO. _____ REG. DIST. NO. 131 PRIMARY REG. DIST. NO. 3023 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Polk</u>	
b. CITY OR TOWN <u>Clinton</u>		c. CITY OR TOWN <u>Flemington</u>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Witzel</u>			
STREET ADDRESS (If real, give location)			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Clarence</u> b. (Middle) <u>Ben</u> c. (Last) <u>Mc Coy</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3 4 55</u>		
5. SEX <u>MO</u>		6. COLOR OR RACE <u>wh.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	
8. DATE OF BIRTH <u>9-26-1888</u>		9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired filling Sta op</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Hull Nebraska</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>J. L.</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs. Beak</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Bessie Mc Coy Flemington Mo</u> ADDRESS.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Medullary Failure</u>		DUE TO (b) <u>Cerebral Thrombosis</u>		<u>6 days</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>Arteriosclerosis</u>		<u>year</u>	
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 <u>332X</u>		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) m.		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 2-27, 1955, to 3-4, 1955, that I last saw the deceased alive on 3-4, 1955, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) <u>Clarence Ben Mc Coy</u>		23b. ADDRESS <u>Clinton Mo</u>		23c. DATE SIGNED <u>Mar 4 55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/4/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Flemington Cem</u>	
24d. LOCATION (City, town, or county) (State) <u>Flemington Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Phonance Adair Beckwith</u>		ADDRESS <u>Humasville</u>	
DATE REC'D BY LOCAL REG. <u>Mar-4-55</u>		REGISTRAR'S SIGNATURE <u>Phonance Adair Beckwith</u>		ADDRESS <u>Humasville</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

20

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..... *O. H. Beckwith*

Licensed Embalmer No. *3987*

P. O. Address *Honolulu*

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.