

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 29 1955

State File No. **25626**

BIRTH NO. _____ REG. DIST. NO. **71** PRIMARY REG. DIST. NO. **5282** Registrar's No. **76**

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, write RURAL and give township) Rural-Fishing River		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN Lawson
d. FULL NAME OF HOSPITAL OR INSTITUTION Rock Island Overpass 69 Highway - Miles West of Excelsior Springs		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED a. (First) ARTHUR		b. (Middle)	c. (Last) MEDLEY

4. DATE OF DEATH Aug 5 1955	5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 20-1904	9. AGE (In years last birthday) 50	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Labor	11. BIRTHPLACE (City and State or Foreign Country) Plad Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jeremiah Medley	13b. MOTHER'S MAIDEN NAME Martha Breedlove	14. NAME OF HUSBAND OR WIFE Mrs Scenie Medley
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 708-10-9508	17. INFORMANT'S SIGNATURE OR NAME Mrs Scenie Medley	ADDRESS Lawson 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: 4201		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE D. J. Pate M.D. (Coroner)	(Degree or title)	23b. ADDRESS North Kansas City, Mo	23c. DATE SIGNED 8/8/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/5/55	24c. NAME OF CEMETERY OR CREMATORY Lawson Cemetery	24d. LOCATION (City, town, or county) (State) Lawson Missouri
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DATE REC'D BY LOCAL REG. 8/16/55	REGISTRAR'S SIGNATURE Caroline Hutchings	25. FUNERAL DIRECTOR'S SIGNATURE Virgil Hope	ADDRESS Excelsior Springs, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



FEB 7
1958

AUG 29 1958

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~~ ~~not~~ ~~embalmed~~. Want Undertaker in another Town Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed James A. Mole
Licensed Embalmer No... 3296

P. O. Address Excelsior S

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.