

FILED AUG 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26304

3324

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>5 weeks</u>		c. CITY OR TOWN <u>Mt. Vernon</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>Goss N.H.-2800 E. 10th</u>				STREET ADDRESS (If rural, give location) <u>unknown</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>DAVID</u>		b. (Middle) <u>L.</u>		c. (Last) <u>McCUBBIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 2, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 30, 1876</u>		9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Iberia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>David A. McCubbin</u>			13b. MOTHER'S MAIDEN NAME <u>Drace</u>			14. NAME OF HUSBAND OR WIFE <u>Ollie McCubbin</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 ADDRESS <u>David L. McCubbin, jr., 4143 Brooklyn, K.C. 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u> <u>331X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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>6-1-55</u> , 19 <u>55</u> , to <u>8-2-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-2-55</u> , 19 <u>55</u> , and that death occurred at <u>8:30 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE OF Informant (Name, degree or title) <u>Frank Paul Laurenzana MD</u>				23b. ADDRESS <u>428 South Whitelove</u>		23c. DATE SIGNED <u>8-2-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-2-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon, Missouri</u>		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>8-2-55</u>		REGISTRAR'S SIGNATURE <u>Deva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE & McCLURE UND. CO.</u>		ADDRESS <u>K.C. MO.</u>	

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

Dr. Lira... will be
at Long Nursing Home
144 Independence Ave
from 1 to 2 P.M.

SEP 28 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb
by me, or by Student Embalmer No.
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed *J. T. Cronell*.....

Licensed Embalmer No. *H. 9.*
P. O. Address *H. C. m.*

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.