

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **32300**

FILED OCT 31 1955

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1122

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| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> | | c. CITY OR TOWN <u>St. Joseph</u> | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <u>25 Yrs</u> | | e. STREET ADDRESS (If rural, give location) <u>825 Frederick Ave.</u> | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u> | | | |

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| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Dr. Cecelia</u> | b. (Middle) <u>A</u> | c. (Last) <u>McGill</u> | 4. DATE OF DEATH (Month) (Day) (Year) |
| | | | | <u>Oct. 21, 1955</u> |

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|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|----------------------|---------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Mar. 28, 1902</u> | 9. AGE (In years last birthday) <u>53</u> | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HR. Hours | IF UNDER 1 HR. Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|----------------------|---------------------|

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|--|-----------------------------------|--|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) | 12. CITIZEN OF WHAT COUNTRY? |
| <u>Medical Doctor</u> | <u>Gen. Practise</u> | <u>Cottonwood, Minn.</u> | <u>U.S.A.</u> |

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| 13a. FATHER'S NAME <u>Thomas King</u> | 13b. MOTHER'S MAIDEN NAME <u>Anna Vallely</u> | 14. NAME OF HUSBAND OR WIFE <u>Dr. Paul McGill</u> |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Dr. Rose V. Will</u> | ADDRESS <u>Wayzata, Minn.</u> |
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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 <u>6 hrs.</u> <u>5 YEARS</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebral hemorrhage</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertension</u> DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</u> | | | |

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| 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) |
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| 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? |
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22. I hereby certify that I attended the deceased from 10/20, 1955, to 10/21, 1955, that I last saw the deceased alive on 10/20, 1955, and that death occurred at 7:15 p.m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>John C. Gray M.D.</u> | 23b. ADDRESS <u>420 N. 8th St. Joseph, Mo.</u> | 23c. DATE SIGNED <u>10/21/55</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>Oct. 24, 1955</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Minneapolis, Minn.</u> |
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| DATE REC'D BY LOCAL REG. <u>Oct 24, 1955</u> | REGISTRAR'S SIGNATURE <u>Esther M. Allison</u> | 485- FUNDAL DIRECTOR'S SIGNATURE <u>Herman W. Sidenfaden</u> | ADDRESS <u>St. Joseph, Mo.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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

DEC 16 1955

JUL 31 1957

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 *Robert H. Gypke*

Licensed Embalmer No. 3308

P. O. Address St. Joseph,

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.