

FILED JAN 9 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40339**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **140** PRIMARY REG. DIST. NO. **3024** Registrar's No. **107**

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Fayette,</b>	c. LENGTH OF STAY (In this place) <b>5 da.</b>	c. CITY OR TOWN <b>Fayette</b>	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 <b>Lee Hospital</b>		STREET ADDRESS (If rural, give location) <b>S. Main St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b>	b. (Middle) <b>Thomas</b>	c. (Last) <b>McBee</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 19, 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 13, 1870</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Howard Co. Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William McBee</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Maxwell</b>	14. NAME OF HUSBAND OR WIFE <b>EvarLee True</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Wm. M. McBee-730 Clara-St. Louis Mo</b>	ADDRESS <b>730 Clara-St. Louis Mo</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>under</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>arteriosclerotic heart disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>similarity</b> DUE TO (c) <b>4200</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>upper respiratory infection</b>		<b>4 days</b>	

19a. DATE OF OPERATION <b>none</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT OR SUICIDE OR HOMICIDE (Specify) <b>natural</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>none</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>10:20 A.M.</b>	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 **July 19, 1950**, to **Dec 19, 1955**, that I last saw the deceased alive on **Dec 19, 1955**, and that death occurred at **10:20 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Wm J. Shaw, Jr M.D.</b>	23b. ADDRESS <b>Lee Hospital, Fayette, Mo</b>	23c. DATE SIGNED <b>12-22-55</b>
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24a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>	24b. DATE <b>12/21/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Howard Co. Missouri</b>
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DATE REC'D BY LOCAL REG. <b>12-22-55</b>	REGISTRAR'S SIGNATURE <b>Mary K. Shell</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Carr</b>	ADDRESS <b>Fayette, Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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, ~~only~~ ....., Student Embalmer No. .... working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed *Ralph A. Cass*.....

Licensed Embalmer No. *337*

P. O. Address *Fayette*

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.