

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item-18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 13 1956

STANDARD CERTIFICATE OF DEATH

272660

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar 393

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>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Independence, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Indep. Sanitarium</u> Length of stay in lb <u>2 yrs</u>		d. STREET ADDRESS <u>Rest Haven</u> (If outside, give location) ¹⁰ <u>9</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>James Mc Connaughey</u> First Middle Last			4. DATE OF DEATH <u>Sept. 3-1956</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan-15-1858</u>		9. AGE (In years last birthday) <u>98</u> IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>		11. BIRTHPLACE (City and state or country) <u>Jafferson Co. Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Mc Connaughey</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Wallace</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Jessie Dowd - Akron, Ohio</u> Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE-(a) <u>Pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis, generalized</u>		Years	
DUE TO (c) <u>Senility</u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Self inflicted superficial laceration of neck.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year <u>4:50 P.M.</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from 11-9-54 to 9-3-56 and last saw him alive on 9-3-56
Death occurred at 5:55 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Drs. Grabske & Link</u> <u>Vance E. Link, M.D.</u> (Degree or title)		22b. ADDRESS <u>10901 Winner, Indep., Mo.</u>		22c. DATE SIGNED <u>9-4-56</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Sept 5-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Barberton Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Barberton Iowa</u>	
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24. FUNERAL DIRECTOR <u>Roland R. Grabske - Indep. Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-5-56</u>		26. REGISTRAR'S SIGNATURE <u>James [Signature]</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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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, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Joland R. [Signature]*

Licensed Embalmer No. *360*

P. O. Address *Indy, IN*

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.