

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

KC 2582784 RL6096 SL 9802D SEP 6 1956		THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH		28787 STATE FILE NUMBER
Registration District No. 318		Primary Registration District No. 1003		Registrar's No. 7072
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Audrain		
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN 915 N. Grand, St. Louis, Mo. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Vandalia Inside Limits 0041 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 509 West Union (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. Hospital Length of stay in lb 84 days		4. DATE OF DEATH 7-25-56		
3. NAME OF DECEASED (Type or print) First John Middle Last Mc Crary		9. AGE (In years birthday) 78 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (City and state or country) Fayette, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bill Mc Crary		
14. MOTHER'S MAIDEN NAME Louisa Phillips		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SPAW		
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address VA HOSPITAL RECORDS, ST. LOUIS, MO.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACTIVE PULMONARY TUBERCULOSIS				INTERVAL BETWEEN ONSET AND DEATH Undetermined
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)				002 X
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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 _____ Minute _____ Day _____ Year _____ a. m. p. m.		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. /VA attended the deceased from 5-2-56 to 7-25-56 and last saw him alive on 7-25-56 Death occurred at 8:15 pm m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>Hy. Westphalinger</i> (Print name or title)		22b. ADDRESS 915 N. Grand V.A.H., ST. LOUIS, MO.		22c. DATE SIGNED 7-26-56
23a. BURIAL CREMATION REMOVAL (Specify) Removal		23b. DATE 7/31/56	23c. NAME OF CEMETERY OR CREMATORY. National Cemetery	
23d. LOCATION (City, town, or county) (State) Jefferson Brks. Mo.		24. FUNERAL DIRECTOR ADDRESS G. Wade Granberry 4202 Finney Ave.		
25. DATE RECD. BY LOCAL REG. JUL 30 1956		26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>		

STATEMENT BY LICENSED EMBALMER

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

Student
Signature of Student Embalmer

Signed *Melora E. Gue*

Licensed Embalmer No. *4*

P. O. Address *St. L.*

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