

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29642

State File No. ....

FILED AUG 28 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 79

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u>		c. CITY OR TOWN <u>Sarcoxie</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>2mo. 27da</u>		e. STREET ADDRESS (If rural, give location) <u>1623 W. Center</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Hosp # 3</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Clyde</u>	b. (Middle) <u>William</u>	c. (Last) <u>McNallie</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>8 10 56</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 7, 1881</u>	9. AGE (in years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Mins. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Jasper Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		

13a. FATHER'S NAME <u>Dennis McNallie</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Swindle</u>	14. NAME OF HUSBAND OR WIFE <u>Myrtle McNallie</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>486-24-5884</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Myrtle McNallie</u>	ADDRESS <u>Sarcoxie, Mo</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several months</u> <u>several years</u> <u>several years</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>generalized arterio-sclerosis</u>		
	DUE TO (c) <u>Chronic Brain Syndrome &amp; Cerebral-arterio-sclerosis &amp; psychosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arterio-sclerosis &amp; psychosis</u>			<u>several years</u>

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>4221</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>None</u>

22. I hereby certify that I attended the deceased from May 14, 1956, to Aug 10, 1956, that I last saw the deceased alive on Aug 10, 1956, and that death occurred at 10:40p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Lester H. Wright M.D.</u>	23b. ADDRESS <u>State Hospital #3, Nevada Mo</u>	23c. DATE SIGNED <u>Aug 10, 1956</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8-10-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sarcoxie, Mo. Cem.</u>
		24d. LOCATION (City, town, or county) (State) <u>Sarcoxie, Mo.</u>

DATE REC'D BY LOCAL REG. <u>8-22-56</u>	REGISTRAR'S SIGNATURE <u>Anna E. Furg</u>	25. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS <u>Jackson &amp; Sons Sarcoxie Mo</u>
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(Licensed Embalmer's Statement on Reverse Side) Wm. F. Jackson

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

4510

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 *Wm F Jackson*.....

Licensed Embalmer No. *395*.....

P. O. Address *Sarasota*.....

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.