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 MAR 4 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 3785

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 185

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph. Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Joseph's Hosp. Length of stay in 1b 4yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buch.
c. CITY OR TOWN St. Joseph, Mo. 0113 0 Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 1802 So. 37th. St. Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Dennis Middle Joseph Last McCarthy

4. DATE OF DEATH Month Feb. Day 18 Year 1957

5. SEX Male

6. COLOR OR RACE White 0

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ 0 DIVORCED ☐

8. DATE OF BIRTH Dec. 14, 1952

9. AGE (In years last birthday) 4 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----------

10b. KIND OF BUSINESS OR INDUSTRY ----------

11. BIRTHPLACE (City and state or country) St. Joseph, Missouri 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas McCarthy

14. MOTHER'S MAIDEN NAME Margie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --------

16. SOCIAL SECURITY NO. --------

17. INFORMANT Address Thomas McCarthy-St. Joseph, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 day

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1/18/57, to 1/18/57 and last saw her/him alive on 1/18/57
Death occurred at 11:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Charles F. Sheehan, M.D.

22b. ADDRESS 902 Edmond St. City

22c. DATE SIGNED 1/19/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 2/21/1957

23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery

23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri

24. FUNERAL DIRECTOR ADDRESS Barry-Harman F.H. St. Joseph, Mo.

25. DATE RECD. BY LOCAL REG. Feb 25, 1957

26. REGISTRAR'S SIGNATURE Esther M. Allison

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Charles M. Harman

Licensed Embalmer No. 44

P. O. Address Watkins

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.