

Health,
& Welfare
S. Public
with Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43297

STATE FILE NUMBER

FILED NOV 19 1957

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 179

S. 300
v. 1-57

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1. PLACE OF DEATH a. COUNTY VERNON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JASPER		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON TOWNSHIP		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN CARTHAGE 049		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSP. # 3		Length of stay in lb. 2 MONTHS + 21 DAY	d. STREET ADDRESS (If outside, give location) 315 NORTH MC GREGOR		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle NEWTON Last MC COY			4. DATE OF DEATH Month NOVEMB. Day 10. Year 1957		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 27. 1889	9. AGE (In years last birthday) 68 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) FARMER		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) MISSOURI ALMA, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME ERASTUS MC COY		13b. MOTHER'S MAIDEN NAME THANEY ANN MATHYS		14. NAME OF HUSBAND OR WIFE BERTHA MC COY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---	17. INFORMANT HOSPITAL RECORDS 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) PNEUMONIA					INTERVAL BETWEEN ONSET AND DEATH 1 WEEK
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) INFLUENZA					1 WEEK
DUE TO (c) _____					480X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) GENERALIZED ARTERIO SCLEROSIS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <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 _____ 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. I attended the deceased from AUGUST 20. 1957 to NOV. 10. 1957 and last saw her alive on NOV. 10. 1957 Death occurred at NOV. 10. 1957 m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) George Carter M.D.			22b. ADDRESS State Hospital No. 3.		22c. DATE SIGNED 11/10/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removed	23b. DATE 11-10-57	23c. NAME OF CEMETERY OR CREMATORY Tark Cemetery		23d. LOCATION (City, town, or county) (State) Carthage Mo.	
24. FUNERAL DIRECTOR Euel Montague - Carthage Mo		ADDRESS _____	25. DATE RECD. BY LOCAL REG. 11-13-1957		26. REGISTRAR'S SIGNATURE Anna E. Ferry

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Royal C McCall*

Licensed Embalmer No. *4853*
P. O. Address *Florida, Mo.*

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.