

FILED DEC 31 1957

STANDARD CERTIFICATE OF DEATH

449180
STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 214

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>LACLEDE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>DALLAS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEBANON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>BUFFALO</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>ONG NURSING Home</u>		Length of stay in 1b <u>1/2 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>0300</u> Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>S</u> Last <u>McELHINNEY</u>			4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1957</u>		
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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>9-29-1866</u>	9. AGE (In years last birthday) <u>91 yrs</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR OF MEDICINE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Schuyler Co Mo</u>	11. BIRTHPLACE (City and state or country) <u>Schuyler Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Hubert McElhinney</u>	13b. MOTHER'S MAIDEN NAME <u>Charlotte</u>	14. NAME OF HUSBAND OR WIFE <u>Walter Falls</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>4201</u>	17. INFORMANT <u>Mrs Clyde Ransom Idaho</u> Address <u>Idaho Falls</u>
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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>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cardiac Decompensation</u>		<u>30 Min.</u>
	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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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 _____ 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
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21. I attended the deceased from Nov 1957 to Dec-16-57 and last saw her alive on Dec-16-57
Death occurred at 6:25 pm Dec 16-57 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>D. O. Bolner</u>	22b. ADDRESS <u>Lebanon, Missouri</u>	22c. DATE SIGNED <u>12-23-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-18-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	23d. LOCATION (City, town, or county) (State) <u>Bolner Mo</u>
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24. FUNERAL DIRECTOR <u>L B Jones</u>	ADDRESS <u>Buffalo Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-23-1957</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

+24
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Received DEC 30 1957
Laclede County Health Unit
File No. 214
Date Filed DEC 30 1957

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 Leonard Stone

Licensed Embalmer No. 2508

P. O. Address Buffalo

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.