

FILED MAR 25 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012933

STATE FILE NUMBER

Registration District No. 352 Primary Registration District No. 6193 Registrar's No. 19

| | | | | | | | | | | | | |
|--|------------------------------|---|--|--|--|--|---|---|------------------------------------|------------------|-------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Taney</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Taney</u> | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hallister</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>Hallister</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> | | | Length of stay in lb <u>10 yrs</u> | | d. STREET ADDRESS (If outside, give location) <u>Rural Rt</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Nancy Loretta McRay</u> | | | | 4. DATE OF DEATH Month Day Year <u>3-19-58</u> | | | | | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</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>11-29-1861</u> | | 9. AGE (In years last birthday) <u>96</u> | | F UNDER 1 YEAR Months Days Hours Min. <u>3 21</u> | | IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (City and state or country) <u>Princeton Indiana</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 13a. FATHER'S NAME <u>Andrew Gillispy</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Rosann Owsenough Despard</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Adolph Meyers</u> | | | | | | |
| 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>none</u> | | | 17. INFORMANT <u>Adolph Meyers</u> | | | Address <u>Hallister Mo</u> | | | |
| 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>Arteriosclerotic Heart Disease</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Gen. arteriosclerosis</u> | | DUE TO (c) _____ | | 4200 | | | | | | |
| 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.) <u>2</u> | | | | | | | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ | | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 <u>April 55</u> to <u>3-19-58</u> and last saw her <u>him</u> alive on <u>3-19-58</u> Death occurred at <u>11:57 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>W. C. Magnus, M.D.</u> | | | | | | 22b. ADDRESS <u>Branson Mo</u> | | | 22c. DATE SIGNED <u>3-21-58</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>3-22-58</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Clark Memorial Park</u> | | | | 23d. LOCATION (City, town, or county) (State) <u>Branson Mo</u> | | | | |
| 24. FUNERAL DIRECTOR <u>Whelchel L. Home</u> | | | ADDRESS <u>Branson Mo</u> | | | 25. DATE RECD. BY LOCAL REG. <u>3-21-58</u> | | 26. REGISTRAR'S SIGNATURE <u>Debra Campbell</u> | | | | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Minnie S. Welch*

Licensed Embalmer No. *2277*
P. O. Address *Branford*

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.