

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013329

FILED MAY 5 1958

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 441
STATE FILE NUMBER

300
-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Doniphan 8/150	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Troy
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		Length of stay in lb 7 Days	d. STREET ADDRESS (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Ernest Abraham McCurry			4. DATE OF DEATH Month Day Year Feb. 16, 1958	
--	--	--	---	--

5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1876	9. AGE (In years last birthday) 81	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) Laborer (Ret.)	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Osage County, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME Samuel C. McCurry	13b. MOTHER'S MAIDEN NAME Eliza Anthony	14. NAME OF HUSBAND OR WIFE Maude V. ?
---	--	---

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. None	17. INFORMANT Address Topeka, Kans. Asa A. McCurry, 1173 Lincoln Street
--	---------------------------------	---

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>encephalomalacia, at cerebellum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 days +</u> <u>2 yrs +</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis, cerebral</u>	
	DUE TO (c) <u>332 X</u>	
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 checked="" type="checkbox"/> NO <input 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 <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>26 Nov 50</u> to <u>death</u> and last saw him alive on <u>15 Feb 1958</u> Death occurred at <u>6:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <u>Emerson Joder M.D.</u> (Degree or title)	22b. ADDRESS <u>Denton, Kans</u>	22c. DATE SIGNED <u>25 Feb 58</u>
---	-------------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb 19, 1958	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City, town, or county) Troy, Kansas
--	---------------------------	--	---

24. FUNERAL DIRECTOR <u>Wm. H. Alexander</u> ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. <u>April 29, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Goodell</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 *Wm. H. Alexander*

Licensed Embalmer No. *4450*
P. O. Address *St. Joseph,*

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.