Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-031833
STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 987

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St.Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3325 S. 11 Parkview Nursing Home — Length of stay in lb 50 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St.Joseph 0117 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 821½ South 9th (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Mary Middle Last McCan

4. DATE OF DEATH Month Sept. Day 6, Year 1958

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH June 24,1884
9. AGE (In years last birthday) 74 — 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) House keeper
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (City and state or country) Nodaway,Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Walsh
13b. MOTHER'S MAIDEN NAME Ellen McCue
14. NAME OF HUSBAND OR WIFE R.M.McCan,(de)

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. none
17. INFORMANT Joseph McCan, Address 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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 331X
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 [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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 8/30/58, to Sept.6,1958 and last saw her/him alive on Sept.6,1958
Death occurred at 10:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Collis Roundy M.D.
22b. ADDRESS Social Welfare Board 10th & Olive,St.Joseph,Mo.
22c. DATE SIGNED 9/8/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 9/9/58
23c. NAME OF CEMETERY OR CREMATORY Mt.Auburn Cemetery
23d. LOCATION (City, town, or county) (State) St.Joseph, Missouri

24. FUNERAL DIRECTOR John E. Rupp ADDRESS St.Joseph,Mo.
25. DATE RECD. BY LOCAL REG. Sept. 18, 1958
26. REGISTRAR'S SIGNATURE Mrs Clark Goodall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Collis Roundy

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, ~~only~~ ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 3986

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.