

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043130
STATE FILE NUMBER

FILED JAN 5 1958 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 405

300
1-57

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY Bonaparte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		c. CITY OR TOWN Bonaparte	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hospital		d. STREET ADDRESS (If outside, give location) R. F. D.	
3. NAME OF DECEASED (Type or print) First Clarence Middle B. Last McCrary		4. DATE OF DEATH Month Dec. Day 24 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Van Buren Co., Iowa
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE X
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. X	17. INFORMANT Address Keith McCrary, Bonaparte, Iowa
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Azotemia DUE TO (b) Chronic Glomerulo-nephritis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) abscess in cervical area			INTERVAL BETWEEN ONSET AND DEATH unknown unknown
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 _____ a.m. _____ p.m. Month, Day, Year _____		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 12-7-58 to 12-24-58 and last saw ^{him} alive on 12-24-58 Death occurred at 11:55 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Grace E. Sawyer, D.O.</i>		22b. ADDRESS Kirksville, Mo.	
22c. DATE SIGNED 12-25-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/25/58	23c. NAME OF CEMETERY OR CREMATORY Bonaparte Cent.	23d. LOCATION (City, town, or county) (State) Bonaparte, Iowa
24. FUNERAL DIRECTOR <i>Paul W. Riley</i> Kirksville, Mo.		25. DATE RECD. BY LOCAL REG. 12-29-1958	26. REGISTRAR'S SIGNATURE <i>Doris W. Raloff</i>

(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.

GRACE E. SAWYER, D.O.

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 *Kenneth E. Hayes*

Licensed Embalmer No. *4890*
P. O. Address *Richville, 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.