

alth,
elfare
lic
vice

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000313

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph 0117	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Parkview N.H.		d. STREET ADDRESS (If outside, give location) 224 E. Hyde Park Ave.	
Length of stay in lb Life		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) DAVID M. MCCAIN			4. DATE OF DEATH January 9, 1959		
First		Middle		Last	

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1882	9. AGE (In years last birthday) 76	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days	12. UNDER 24 HRS. Hours	13. UNDER 24 HRS. Min.
-------------	------------------------	--	--------------------------------	------------------------------------	-------------------------	------------------------	-------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Stock Yd. Co.	11. BIRTHPLACE (City and state or country) Buchanan Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	-------------------------------------

13a. FATHER'S NAME James P. McCain	13b. MOTHER'S MAIDEN NAME Martha J. Cocks	14. NAME OF HUSBAND OR WIFE Margaret Grace McCain (deceased)
------------------------------------	---	--

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. 487-07-9873	17. INFORMANT Address Mrs. Gladys Davis, 1207 Powell St.
--	-------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic bronchitis with pulmonary emphysema with cor-pulmonale.	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arrested fibrotic pulmonary tuberculosis. 5020A		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 <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 Mar. 1955 to Jan. 6, 1959 and last saw her alive on Jan. 6, 1959. Death occurred at 9:25 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Martin H. Christ M.D.	22b. ADDRESS 6106 King Hill Ave.	22c. DATE SIGNED 1-9-59
--	----------------------------------	-------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 12, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
--	-------------------------	--	--

24. FUNERAL DIRECTOR [Signature] St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Jan. 11, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

Dr. Martin H. Christ
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All arrests 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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John E. Rupp*

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.