

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000314

STATE FILE NUMBER

127

FILED FEB 9 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

300
-57

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 508 1/2 S. 6th St.		Length of stay in 1b unknown	d. STREET ADDRESS (If outside, give location) 508 1/2 S. 6th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM RAMSEY MC CARTY			4. DATE OF DEATH Month Day Year Jan. 28, 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1920	9. AGE (In years last birthday) 38	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) Section Hand		10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.	11. BIRTHPLACE (City and state or country) Owensville, Kentucky		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Banks McCarty		13b. MOTHER'S MAIDEN NAME Lillie Goodpaster		14. NAME OF HUSBAND OR WIFE Irene	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes W.W. #11		16. SOCIAL SECURITY NO. 489-22-6407		17. INFORMANT Mrs. Lillie McCarty, Weston, Mo.	
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>Sarany occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH 3 Mon.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					4201
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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>maternity</u> and last saw her alive on _____ Death occurred at <u>8:15p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE ASSISTANT City Health Officer <u>[Signature]</u>				22b. ADDRESS Weston Missouri	
22c. DATE SIGNED 2-5-59					
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1/29/1959		23c. NAME OF CEMETERY OR CREMATORY Weston Missouri	
23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR Heston-Bowman		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Feb. 6, 1959	
26. REGISTRAR'S SIGNATURE Wm. Clark Goodell					

All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.
 MEDICAL CERTIFICATION
 Dr. L. H. Pifer

W. E. Fisher
1302 Harrison

FEB 11 1959

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 *Arthur V. Herrick*
Licensed Embalmer No. *64848*
P. O. Address *K. C. 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.