

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001956

STATE FILE NUMBER

JAN 19 1959

Registration District No. 175 Primary Registration District No. 51645 Registrar's No. 44

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Lawrence</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Aurora</u>  |                               | c. CITY OR TOWN <u>Aurora</u>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 miles North</u>  |                               | d. STREET ADDRESS <u>R#1</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) First <u>John</u> Middle <u>A.</u> Last <u>McNatt</u>  |                               | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>9.</u> Year <u>1959</u>   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 23, 1881</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country) <u>Lawrence Co. U.S.A.</u>                          |
| 13a. FATHER'S NAME <u>Washington McNatt</u>   |                               | 14. NAME OF HUSBAND OR WIFE   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>   |                               | 17. INFORMANT <u>Mrs. Norman Calhoun</u> Address <u>200 W of Aurora</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>  |                               |   | INTERVAL BETWEEN ONSET AND DEATH <u>stat.</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Varicose Veins + Phlebitis (Recurrent) 10 yrs</u>   |                               |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Peptic Ulcer</u>   |                               |   | 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.) <u>460X</u>  |  |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.   |                               | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                               | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |  |
| 21. I attended the deceased from <u>2/27/50</u> to <u>1/5/59</u> and last saw him <u>live on 1/5/59</u><br>Death occurred at <u>7:10 a.m.</u> on the date stated above; and to the best of my knowledge from the causes stated. |                               |   |  |
| 22a. SIGNATURE (Deed or Title) <u>Benneth Glover MD</u>   |                               | 22b. ADDRESS <u>Mr. Eason, Mo.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE <u>1/19/59</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>  |                               | 23d. LOCATION (City, town, or county) (State) <u>Aurora, Mo.</u>  |  |
| 24. FUNERAL DIRECTOR <u>Marsh Funeral Home, Aurora, Mo.</u>   |                               | 25. DATE RECD. BY LOCAL REG. <u>1-13-1959</u>   |  |
| 26. REGISTRAR'S SIGNATURE <u>Oral Mc Natt</u>   |                               |   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 Ray B. Ireland

Licensed Embalmer No. 5052  
P. O. Address Aurora, 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.