

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004855  
STATE FILE NUMBER

FILED FEB 26 1959

Registration District No. 77

Primary Registration District No. 3014

Registrar's No. 19

300  
1-57 0

1. PLACE OF DEATH a. COUNTY <u>Platte</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		c. CITY OR TOWN <u>Excelsior Springs</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		600 2 <sup>1/2</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs</u>		d. STREET ADDRESS (If outside, give location) <u>506 Park St.</u>	
Length of stay in lb <u>540</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES</u> <u>MCQUE</u>			4. DATE OF DEATH Month Day Year <u>Feb 9 - 59</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4 - 1881</u>
9. AGE (In years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Mo. U.S.A.</u>
10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Mc Cue</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Kincaid</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>W.M. Mc Cue - Kirkwood, Mo.</u>		Address	
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>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sev. days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <u>arteriosclerosis</u>			years
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</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.)	
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 <u>Feb. 5, 1959</u> to <u>Feb. 9, 1959</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>Feb. 9, 1959</u> Death occurred at <u>2:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Excelsior Springs, Mo.</u>	
		22c. DATE SIGNED <u>2/15/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb-12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodland</u>
		23d. LOCATION (City, town, or county) (State) <u>Platte Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>Church-Brewer Co. Liberty, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2/16/59</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</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 *John Lumber* .....

Licensed Embalmer No. *4448* .....  
P. O. Address *2. Liberty, 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.