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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006043
STATE FILE NUMBER

FILED FEB 20 1959 Registration District No. 158 Primary Registration District No. 5572 Registrar's No. 50

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Co. Hosp. — Length of stay in 1b 9 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Hickman Mills — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS 116th & Westview Rd (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First William Middle Artis Last McCubbin

4. DATE OF DEATH Month Feb. Day 13 Year 1959

5. SEX male

6. COLOR OR RACE white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH Aug. 8, 1908

9. AGE (In years on last birthday) 50 — 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) Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (City and state or country) Osceola, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Seth McCubbin

13b. MOTHER'S MAIDEN NAME Rebecca Cannady

14. NAME OF HUSBAND OR WIFE Ethel McCubbin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 496-10-7622

17. INFORMANT Records Jackson Co Hosp. Indep Mo

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured Gastric Ulcer
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5400

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

All diseases in Part I must be causally related.

21. I attended the deceased from 2-4-59, to 2-13-59 and last saw her/him alive on 2-12-59. Death occurred at 1:50 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Philip Haper (Degree or title) M.D.

22b. ADDRESS Lees Summit, Mo

22c. DATE SIGNED 2-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 2/15/59

23c. NAME OF CEMETERY OR CREMATORY Caseville

23d. LOCATION (City, town, or county) Caseville Mo (State)

24. FUNERAL DIRECTOR Langford Funeral Home — **ADDRESS** Lees Summit

25. DATE RECD. BY LOCAL REG. 2/14/59

26. REGISTRAR'S SIGNATURE M B Langford

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.