

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006302

STATE FILE NUMBER

FILED MAR 16 1959

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 26

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Linn</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Brookfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McParney Hospital</u>		Length of stay in 1b <u>6 1/2 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>R. 7. D. # 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Fern</u> Middle <u>Agatha</u> Last <u>McGregor</u>			4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24, 1909</u>	9. AGE (In years last birthday) <u>49</u>	10. F UNDER 1 YEAR Months <u>10</u> Days <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cosmetic Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug store</u>	11. BIRTHPLACE (City and state or country) <u>Barlington, Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
11a. FATHER'S NAME <u>Guy D. Simpson</u>		11b. MOTHER'S MAIDEN NAME <u>Pora B. Warren</u>		11c. NAME OF HUSBAND OR WIFE <u>Herald McGregor</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>491-22-7396</u>	17. INFORMANT Address <u>Herald McGregor, Brookfield, Missouri</u>		
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>Acute cerebral insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>rupture of cerebral ulcer.</u>			
		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>Cachexia</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>—</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Brookfield, Missouri</u>		20e. COUNTY STATE	
21. I attended the deceased from <u>3/18/59</u> to <u>3/6/59</u> and last saw her/him alive on <u>3/6/59</u> . Death occurred at <u>9:00</u> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>D.W. Bohm M.D.</u> (Degree or title)			22b. ADDRESS <u>Brookfield, Mo.</u>		22c. DATE SIGNED <u>3/6/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rethaven Memorial Garden</u>		23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>
24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-9-59</u>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Dep.</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.

MAR 30 1954

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 *Herald T. Wady* .....

Licensed Embalmer No. *4172* .....

P. O. Address *Browning* .....

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.