

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006828

STATE FILE NUMBER

FILED MAR 13 1959

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 84

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1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Lilbourn <u>0720</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 State Hospital #4		Length of stay in lb 2Y; 5M; 11 das.	d. STREET ADDRESS (If outside, give location) Unknown Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SIDNEY Middle GEORGE Last MCCAIN			4. DATE OF DEATH Month Feb. Day 17, Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1889		9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months 6 Days 25 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Johnson County, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Frank McCain		13b. MOTHER'S MAIDEN NAME Nancy Davis		14. NAME OF HUSBAND OR WIFE Martha Burdin McCain	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 432-16-8865	17. INFORMANT Address Records, State Hospital No. 4, Farmington, Mo.	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 das.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Psychosis with cerebral arteriosclerosis and chronic myocarditis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 Farmington, Missouri	COUNTY 	STATE
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21. I attended the deceased from **Oct. 6, 1955** to **Feb. 17, 1959** and last saw him alive on **Feb. 17, 1959**
Death occurred at **1:30 P. M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) MD	22b. ADDRESS State Hospital No. 4 Farmington, Missouri	22c. DATE SIGNED 2-17-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 19, 1959	23c. NAME OF CEMETERY OR CREMATORY Mounds Park Cemetery	23d. LOCATION (City, town, or county) (State) Near Lilbourn, Missouri
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24. FUNERAL DIRECTOR Ponder Funeral Home, Lilbourn, Mo.	ADDRESS 	25. DATE RECD. BY LOCAL REG. Mar. 2, 1959	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Carl J. Miller*

Licensed Embalmer No. *3953*

P. O. Address *Farmington*

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.