

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013957

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No.

175

Primary Registration District No.

3036

Registrar's No.

53

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Lamar</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Stone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Aurora</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Salina Mo. 1040</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Aurora Hosp.</u>		Length of stay in 1b <u>1 day</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Elizabeth</u> Last <u>McClough</u>			4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>wh.</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>Sept. 6 - 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years last birthday) <u>52</u> IF UNDER 1 YEAR: Months <u>7</u> Days <u>26</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Stone Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ben Baumgardner</u>		13b. MOTHER'S MARDEN NAME <u>Anna Baumgardner</u>	
14. NAME OF HUSBAND OR WIFE <u>John McClough</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>John McClough</u> Address <u>Salina Mo. 1040</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 heart failure.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension - (arterio) Hypertension</u>			<u>9 yrs.</u>
DUE TO (c) <u>arteriosclerosis - atherosclerosis</u>			<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</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 <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>		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>1957</u> to <u>May 1 - 1959</u> and last saw her <u>alive</u> on <u>May 1 - 1959</u> Death occurred at <u>7:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. P. Crone, M.D.</u>		22b. ADDRESS <u>Crone, Mo.</u>	
22c. DATE SIGNED <u>5-2-59</u>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		23b. DATE <u>May 4 - 1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Eisenhower</u>		23d. LOCATION (City, town, or county) (State) <u>near Reed Spring Mo.</u>	
24. FUNERAL DIRECTOR <u>Everett J. Cheatham</u> ADDRESS <u>Salina Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-6-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Ora Mc. Natt</u>			

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Everett J. Cheatham*

Licensed Embalmer No. *3870*

P. O. Address *Halena 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.