

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017371
STATE FILE NUMBER

300
-57

FILED JUN 15 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 551

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield ⁰³⁹⁰	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Burge Hospital		d. STREET ADDRESS (If outside, give location) Route 7	
Length of stay in 1b 2 years		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK WILLIAM McCRADY			4. DATE OF DEATH Month Day Year June 4, 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 March 21, 1900
9. AGE (In years last birthday) 59		10. UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Day 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Company	
11. BIRTHPLACE (City and state or country) Attica, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Alex McCrady		13b. MOTHER'S MAIDEN NAME Carrie Green	
14. NAME OF HUSBAND OR WIFE Nell McCrady			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Nell McCrady		Address Springfield, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) UNATTENDED BY A PHYSICIAN			But relatively short.
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <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 Greene County		STATE Missouri	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 2 P. m of the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James D. Amos, M.D.		22b. ADDRESS Greene County Health Officer Greene County Health Dept., Spfld, Mo	
22c. DATE SIGNED 6-8-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 6, 1959	
23c. NAME OF CEMETERY OR CREMATORY Mission		23d. LOCATION (City, town, or county) (State) Wichita, Kansas	
24. FUNERAL DIRECTOR ADDRESS GORMAN-SCHARPF FUNERAL HOME Springfield, Missouri		25. DATE RECD. BY LOCAL REG. 6-8-59	
26. REGISTRAR'S SIGNATURE Effie E. Meelon			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. All diseases in Part I must be causally related.

JUL 21 1959

JUN 15 1959

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 *Lewis A. Scharpf*

Licensed Embalmer No. *3802*

P. O. Address *Springfield*

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.