

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018317

FILED MAY 25 1959

Registration District No. 383

Primary Registration District No. 5655

STATE FILE NUMBER

Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>		
b. CITY OR TOWN <b>Mt. Vernon</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Sarcoxie</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State San.</b>		Length of stay in lb <b>5 days</b>	d. STREET ADDRESS <b>203 N. 9th</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Ophelia McNallie</b>			4. DATE OF DEATH Month Day Year <b>May 5, 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1889</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physiotherapy Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Sarcoxie, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Dennis McNallie</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Swindle</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>495-01-0698</b>	17. INFORMANT Address <b>San.records, Mo.State San.,Mt.Vernon, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Disseminated tuberculosis of lymph nodes of abdominal cavity, liver, spleen, adrenals, and kidneys</b> DUE TO (b) <b>Pulmonary tuberculosis, Far Advanced</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				INTERVAL BETWEEN ONSET AND DEATH	
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 <b>Sarcoxie</b>		COUNTY <b>Mo.</b>		STATE
21. I attended the deceased from <b>May 1, 1959</b> to <b>May 5, 1959</b> and last saw her alive on <b>May 5, 1959</b> Death occurred at <b>8:20 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Joseph Advisory M.D.</b> (Degree or title)			22b. ADDRESS <b>Mt. Vernon, Mo.</b>		22c. DATE SIGNED <b>5-5-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-5-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sarcoxie</b>		23d. LOCATION (City, town, or county) (State) <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Weanell Pierce City Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-22-59</b>	26. REGISTRAR'S SIGNATURE <b>Cecil Hendricks</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

00-57

MISSOURI DEPARTMENT OF HEALTH, DIVISION OF HEALTH OF MISSOURI, ST. LOUIS, MISSOURI

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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 me....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed R. G. Gonda Bennett.....

Licensed Embalmer No. 4213.....  
P. O. Address Monit, N.....

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.

*[Handwritten scribbles and illegible text at the bottom of the page]*