

D. M. Doniel

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018598

STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. *272*

Primary Registration District No. *4397*

Registrar's No. *96*

1. PLACE OF DEATH a. COUNTY <i>Genessee</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Genessee</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cooter</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Cooter</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>0780</i>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harvey A McKay</i>		4. DATE OF DEATH Month Day Year <i>5-15-59</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>4-10-1878</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	11. BIRTHPLACE (City and state or country) <i>Ursery Ind 1 USA</i>
12a. FATHER'S NAME <i>Isaac McKay</i>		13b. MOTHER'S MAIDEN NAME <i>Opheelia Nathelone</i>	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) <i>no</i>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Miss Mahel McKay Blytheville Ark</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 <i>Minutes</i>
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.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>5-15-59</i> and last saw him <i>Dead</i> alive on <i>5-15-59</i> Death occurred at <i>9:30 AM</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>H. J. Steele MD</i>		22b. ADDRESS <i>Steele MD</i>	22c. DATE SIGNED <i>5-22-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>5-18-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>H. S. Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Cooter MO</i>
24. FUNERAL DIRECTOR <i>Harmon Malt Co</i>		25. DATE RECEIVED BY LOCAL REG. <i>6/6-59</i>	26. REGISTRAR'S SIGNATURE <i>D. M. Doniel</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

~~6-153-59~~

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 *Noel E Deane*

Licensed Embalmer No. *3941*

P. O. Address *Caruthers*

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.