

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019417
STATE FILE NUMBER
2 4447

Registration District No. _____ Primary Registration District No. _____ Registration No. _____

DECEASED MAY 18 1959

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY _____

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Inside Limits Yes No

c. CITY OR TOWN St. Louis Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home 4040 Cottage Length of stay in 1b _____

d. STREET ADDRESS (If outside, give location) 4040 Cottage Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
William C. McNary

4. DATE OF DEATH Month Day Year
May 2 1959

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH Dec. 8, 1896 9. AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) General Hauling 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and state or country) Gibson, Mississippi 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Tim McNary 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE Alice McNary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Alice McNary Address 4040 Cottage

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) cerebro vascular accident INTERVAL BETWEEN ONSET AND DEATH 1 day
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO (b) Arteriosclerosis
DUE TO (c) Atherosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 Nov. 1956 to 5-2-1959 and last saw her alive on 5-2-59
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Russell W. White (Degree or title) RA 22b. ADDRESS 1524 N. Sarah 22c. DATE SIGNED 5-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE May 7, 1959 23c. NAME OF CEMETERY OR CREMATORY Washington Park 23d. LOCATION (City, town, or county) (State) Berkeley 21, Missouri

24. FUNERAL DIRECTOR ADDRESS Price Funeral Home 2829 Washington 25. DATE RECD. BY LOCAL REG. MAY 6 '59 26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

ALL INFORMATION ON THIS FORM MUST BE CAUTIONARILY RETAINED.

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Edward A. Flynn*

Licensed Embalmer No. *4444*

P. O. Address *4227*

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.