

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021532

STATE FILE NUMBER 8710

JUN 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</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>Research Hosp.</b>		Length of stay in 1b <b>9 weeks</b>	d. STREET ADDRESS (If outside, give location) <b>7808 610 So. Huttig</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>T.</b> Last <b>MC LIN</b>			4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1896</b>
9. AGE (In years last birthday) <b>62</b>	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, even if retired) <b>Self-Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	11. BIRTHPLACE (City and state or country) <b>Holden, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>D. A. Mc Lin</b>		13b. MOTHER'S MAIDEN NAME <b>Rose Tevis</b>	14. NAME OF HUSBAND OR WIFE <b>Hallie F. Mc Lin</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W.W.I</b>		16. SOCIAL SECURITY NO. <b>493-14-9466</b>	17. INFORMANT Address <b>Hallie F. McLin, 610 So. Huttig, K.C., 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>Acute Pulmonary Artery Embolization</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Intraventricular mural Thrombosis</b>			<b>2 days</b>
DUE TO (c) <b>Paroxysmal Atrial Fibrillation</b>			<b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Vascular Disease of the Myocardium</b>			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.) <b>4201</b>		
20c. TIME OF INJURY Hour Month, Day, Year 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, bridge, etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>Dec. 20, 1957</b> , to <b>June 1-1959</b> and last saw him alive on <b>June 1-1959</b> Death occurred at <b>3 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Graham Asher M.D.</b>		22b. ADDRESS <b>1270 Professional Bldg Kansas City 6 - 2nd</b>	22c. DATE SIGNED <b>6-2-1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 4, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Independence, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Geo. C. Carson &amp; Sons, Indep., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-2-59</b>	26. REGISTRAR'S SIGNATURE <b>Wes Minshall</b>

Graham Asher USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUL 10 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 *R. Kenneth Patterson*

Licensed Embalmer No. *4697* ..... P. O. Address *Indy, Ind.* .....

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.