

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025755

STATE FILE NUMBER

FILED VS JUL 20 1959

Registration District No. 169 Primary Registration District No. _____ Registrar's No. 38

1. PLACE OF DEATH a. COUNTY <u>Knox</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scotland</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Edina</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rutledge</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gibson Hosp.</u>		Length of stay in lb <u>2 days</u>		d. STREET ADDRESS (If outside, give location) <u>0990</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle _____ Last <u>Mc Cabe</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 7, 1870</u>		9. AGE (In years last birthday) <u>89</u>	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) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Knox County, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Owen McCabe</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Jones</u>			14. NAME OF HUSBAND OR WIFE <u>Nancy McCabe</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Letus McCabe</u>		Address <u>Rutledge, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u>						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fracture of left hip</u>								
DUE TO (c) <u>Cerebral Arteriosclerosis</u>						<u>9047</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Shock subsequent to fall & fracture of hip</u>						<u>45</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT <input checked="" 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.) <u>Pt. fell at Nursing Home at Memphis, Mo.</u>					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. <u>6/29/59</u>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street office bldg., etc.) <u>Nursing Home</u>			20f. CITY, TOWN, OR LOCATION <u>Memphis</u>		COUNTY <u>Scotland</u>		STATE <u>Mo.</u>	
21. I attended the deceased from <u>6/30/59</u> to <u>7/1/59</u> and last saw her/him alive on <u>July 1, 1959</u> Death occurred at <u>3:54 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>W. A. Beckman</u> (Degree or title) <u>2</u>				22b. ADDRESS <u>Edina, Missouri</u>		22c. DATE SIGNED <u>7/15/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 3, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pauline Cemetery</u>		23d. LOCATION (City, town, or country) (State) <u>Rutledge, Missouri</u>			
24. FUNERAL DIRECTOR <u>Arthur Bassett Memphis Mo</u>			25. DATE RECD. BY LOCAL REG. <u>July 18-1959</u>		26. REGISTRAR'S SIGNATURE <u>Neil S. Stewart</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

JUL 21 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 *Albert C. Lenth*

Licensed Embalmer No. *4257*

P. O. Address *Memphis, Tenn.*

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.