

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 5 1959

59-027965

Registration District No. 275 Primary Registration District No. 6284 Registrar's No. 25

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Wright</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Montgomery Township</u>		Length of stay in lb <u>Life</u>		c. CITY OR TOWN <u>Lynchburg</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>Lynchburg (Gen. Delivery)</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Montgomery Township</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Ernest McCoy</u>				4. DATE OF DEATH Month Day Year <u>July 27, 1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1/7/1904</u>	9. AGE (last birthday) <u>55</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>6 20</u>	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>		11. BIRTHPLACE (City and state or country) <u>Wright County, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Joseph McCoy</u>			13b. MOTHER'S MAIDEN NAME <u>Janie McDonaId</u>			14. NAME OF HUSBAND OR WIFE <u>Mrs Lulu Jackson McCoy</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>486-24-2189</u>		17. INFORMANT Address <u>Mrs Lulu McCoy Lynchburg, Missouri</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>Very Extensive Diffuse metastatic melanoma of skin</u> DUE TO (b) <u>Primary melanoma of eye</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last:							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)							
20c. TIME OF INJURY Hour: _____ a.m. _____ p.m. _____									
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.):		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>7/27/59</u> to <u>7/27/59</u> and last saw him alive on <u>7/27/59</u> Death occurred at <u>6:50 P.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W. Roland Langston M.D.</u> (Degree or title)				22b. ADDRESS <u>Springfield</u>				22c. DATE SIGNED <u>7/29/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Dutch Chapel Cemetery</u>		23d. LOCATION (City, town, or county) <u>Wright County, Missouri</u> (State)				
24. FUNERAL DIRECTOR <u>Barber Funeral Home - Mtn. Grove, Missouri</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Aug 3 1959</u>		26. REGISTRAR'S SIGNATURE <u>Bonnie J Jones</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed George Stapp

Licensed Embalmer No. 3661

P. O. Address Mt. Laurel

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.