

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039831

FILED VS. NOV 30 1959

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 99 STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Mo.		c. CITY OR TOWN Fayette	
Length of stay in lb 8 hrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lee Hospital		d. STREET ADDRESS (If outside, give location) Chariton Twp.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First NEWTON Middle ELLIOTT Last McCRARY			4. DATE OF DEATH NOV. 22, 1959 Month NOV. Day 22, Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/23/1888	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (City and state or country) Howard County, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Spencer McCrary	13b. MOTHER'S MAIDEN NAME Fannie Miller	14. NAME OF HUSBAND OR WIFE Sallie E. Miller
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. 489-28-3888A	17. INFORMANT N. B. McCrary Address R.R. Glasgow, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 10 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac decompensation		2 yrs.
DUE TO (c) Arteriosclerosis generalized		3 yrs.
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.)
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20c. TIME OF INJURY Hour 4:00 p.m. Month, Day, Year	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 bldg., etc.)	20f. CITY, TOWN, OR LOCATION Fayette COUNTY Missouri STATE Missouri
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21. I attended the deceased from Jan 1955 to Nov 22-1959 and last saw ^{him} alive on 11-21-59 Death occurred at 4:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Wm J Shaw (Degree or title) M.D.	22b. ADDRESS Fayette, Mo.	22c. DATE SIGNED 11-23-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/24/1959	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) (State) Fayette, Missouri
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24. FUNERAL DIRECTOR Ralph A Case ADDRESS Fayette, Mo.	25. DATE RECD. BY LOCAL REG. 11-23-59	26. REGISTRAR'S SIGNATURE Katherine Welch
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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 m

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Fayette, Va.

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.