

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-040751**

FILED VS NOV 23 1959

164 Registration District No. Primary Registration District No. 5601 Registrar's No. 150

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <b>Johnson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Warrensburg Twp.</b>		Length of stay in 1b <b>48 days</b>		c. CITY OR TOWN <b>Warrensburg</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pleasantview Nursing Home</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Pleasantview Nursing Home R.R.2</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Viola</b> Last <b>McGrady</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-19-1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Morgan Co., Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>John Fogle</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Jane Williams</b>		14. NAME OF HUSBAND OR WIFE <b>George McGrady</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Jake Kraus, Sedalia, Missouri</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>Cerebral vascular accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____		DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Previous C V A with left sided paresis</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.		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		COUNTY STATE	
21. I attended the deceased from <b>Oct, 1959</b> to <b>Nov, 1959</b> and last saw her <b>alive</b> on <b>Nov. 12, 1959</b>				Death occurred at <b>4:55 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. H. Curings, M.D.</i>			(Degree or title)		22b. ADDRESS <b>Warrensburg, Mo.</b>		22c. DATE SIGNED <b>11-21-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 20, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sedalia, Missouri</b>			
24. FUNERAL DIRECTOR <b>M<sup>c</sup>Laughlin Bros. Sedalia</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Nov. 21, 1959</b>	26. REGISTRAR'S SIGNATURE <i>Sedalia Savannah</i>		

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 me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed K. P. M. [Signature]

Licensed Embalmer No. 3153

P. O. Address Sedalia, Mo.

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.