

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 6 3 3

FILED VS JAN - 4 1960 174

Registration District No.

Primary Registration District No. 5644

Registrar's No. 7021

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Lafayette				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington Township		Length of stay in 1b 46 days		c. CITY OR TOWN Aullville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Goodloe Rest Home			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) East side		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ANNA Middle RIDGE Last MC KAY				4. DATE OF DEATH Month November Day 25 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. Days of Birth 11/15/1878	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months 2 Days 11	IF UNDER 24 HR Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Urich, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John W. Ridge			13b. MOTHER'S MAIDEN NAME Mary Brannock			14. NAME OF HUSBAND OR WIFE A.L. McKay, Dec.			
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. None		17. INFORMANT Mrs. Martha McKay Address Columbia, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis.							INTERVAL BETWEEN ONSET AND DEATH 15 minutes		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis							15 yrs		
DUE TO (c) Arteriosclerosis							20 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 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 Oct 24, 1959 to Nov 21, 1959 and last saw her ^{her} alive on 11-22-1959 Death occurred at 7 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Dee or title) Dr. John C. Belton MD				22b. ADDRESS 1110 1/2 main st Lexington Mo				22c. DATE SIGNED 11/25/59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)				
Burial		11/27/1959	City Cemetery		Higginsville Missouri				
24. FUNERAL DIRECTOR ADDRESS A.H. Hader Funeral Home By [Signature] Higginsville, Mo.				25. DATE RECD. BY LOCAL REG. 12-15-59		26. REGISTRAR'S SIGNATURE [Signature]			

(Licensed Embalmer's Statement on Reverse Side)

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 Levan Thurman

Licensed Embalmer No. 4563

P. O. Address Richmond, 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.