

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

FILED VS JAN 19 1960

STATE FILE NUMBER  
**-59-047093**

Registration District No. 362 Primary Registration District No. 6237 Registrar's No. 1

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Warren</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hickory Grove Twsp</u>	c. CITY OR TOWN <u>Wright City</u>	d. STREET ADDRESS <u>Rt.2, Box 180</u>
Length of stay in 1b <u>5 years</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)	First <u>Walter</u>	Middle <u>John</u>	Last <u>McCann</u>	<b>4. DATE OF DEATH</b>	Month <u>December</u>	Day <u>30</u>	Year <u>1959</u>
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<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12/29/94</u>	<b>9. AGE (last birthday)</b> <u>65</u>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Chemical</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Glenwood, Minn.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>
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<b>13a. FATHER'S NAME</b> <u>Arthur McCann</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary Baldreau</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Edna McCann</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u>	<b>16. SOCIAL SECURITY NO.</b> <u>WW T 488-09-7228</u>	<b>17. INFORMANT</b> <u>Edna McCann, Rt.2, Box 180, Wright City</u>	<b>Address</b> <u>Missouri</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <u>Portia Insufficiency</u>		<u>Sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>←</u>	
	DUE TO (c) <u>←</u>	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a) <u>No medical attention in Past 5 yrs.</u>	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour s.m. p.m.	Month, Day, Year
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Rural Wright City, Warren Mo.</u>	<b>20f. CITY, TOWN, OR LOCATION</b> <u>Warren Mo.</u>	<b>COUNTY</b> <u>Warren</u>	<b>STATE</b> <u>Mo.</u>
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**21. I attended the deceased from** ← **to** ← **and last saw her/him alive on** ←  
**Death occurred at** 4.30 p **m** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <u>F. H. Knigge D.C. (Coroner)</u>	<b>(Degree or title)</b>	<b>22b. ADDRESS</b> <u>Intentional Mo</u>	<b>22c. DATE SIGNED</b> <u>Dec 30-59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>removal</u>	<b>23b. DATE</b> <u>1/2/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Memorial Park</u>	<b>23d. LOCATION (City, town, or county)</b> <u>St. Louis Co. Missouri</u>
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<b>24. FUNERAL DIRECTOR</b> <u>BUCHHOLZ MORT. 5967 W. Florissant Ave.</u>	<b>ADDRESS</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>1-2-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Floyd Rogan</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1 29 1960

**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 Elmer R Cadwell

Licensed Embalmer No. 407

P. O. Address St Louis

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.