

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003739

FILED VS. JAN 22 1960

Primary Registration District No. _____

Registrar's No. **2**

197

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oklahoma b. COUNTY Atoka		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b	c. CITY OR TOWN Atoka		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 5		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin Creigh McClearey			4. DATE OF DEATH Month Day Year January 3, 1960		
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 5/5/1874	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Montgomery City, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Josephus McClearey		13b. MOTHER'S MAIDEN NAME Mary Sharpe		14. NAME OF HUSBAND OR WIFE Lennie C. McClearey	
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 Address Lennie C. McClearey, Atoka, Okla.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Amuria					INTERVAL BETWEEN ONSET AND DEATH 3 days
DUE TO (b) Prostate hypertrophy					4 weeks
DUE TO (c) 610x					
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 Month, Day, Year a.m. p.m.					
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 29 Dec. 59 to 3 Jan 60 and last saw ^{her} him alive on 3 Jan 60 Death occurred at 10:00Pm m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE E.H. Busford, M.D. (Degree or title)		22b. ADDRESS 958 Creole Plk., St. Louis, Mo.		22c. DATE SIGNED 1/4/60 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-7-60	23c. NAME OF CEMETERY OR CREMATORY Atoka Cemetery		23d. LOCATION (City, town, or county) Atoka, Okla.	
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Bld. ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 7 1960		26. REGISTRAR'S SIGNATURE Leal Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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