

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-007079

STATE FILE NUMBER

FILED VS MAR 14 1960

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 189

S. 300  
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Mt. Vernon</u> <sup>0550</sup>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bliss Haven</u>		Length of stay in lb <u>2 yn.</u>	d. STREET ADDRESS (If outside, give location) <u>Bliss Haven</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alfred</u> <u>Mc Coy</u>			4. DATE OF DEATH Month Day Year <u>2-25-1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1874</u>		9. AGE (In years last birthday) <u>85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Lawrence Co.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Jim Mc Coy</u>		13b. MOTHER'S MAIDEN NAME <u>Kathryn Garringer</u>		14. NAME OF HUSBAND OR WIFE <u>Miller Mo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>George Dunn</u> Address <u>Miller Mo</u>		
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute circulatory failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>coronary thrombosis</u>			
		DUE TO (c) <u>arteriosclerosis</u> <u>4201</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 <u>8-15-59</u> to _____ and last saw <u>him</u> alive on <u>2-25-60</u> Death occurred at <u>6:20</u> <u>A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Hugh Baker</u> <u>D.O.</u>			22b. ADDRESS <u>Miller Mo.</u>		22c. DATE SIGNED <u>3-4-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pheasant Grove</u>		23d. LOCATION (City, town, or county) (State) <u>S. of Miller Mo.</u>	
24. FUNERAL DIRECTOR <u>Morris - Seiman</u>		ADDRESS <u>Miller Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-7-60</u>	26. REGISTRAR'S SIGNATURE <u>H.H. Forsett</u>

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 *E. P. Leiman* .....

Licensed Embalmer No. *3397* .....

P. O. Address *Miller 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.