

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-018055

FILED VS APR 25 1960

STATE FILE NUMBER

Registration District No. 2 & 1 Primary Registration District No. 4015 Registrar's No. 41

NDED

1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CHARITON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN</u>	Length of stay in 1b <u>6 DAYS</u>	c. CITY OR TOWN <u>MENDON</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MILAN HOSPITAL</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>MAIN STREET</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JESS MCKANE</u>			4. DATE OF DEATH Month Day Year <u>APRIL 13 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1883</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED FARMER</u>	11. BIRTHPLACE (City and state or country) <u>WHEELING, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>ALAN MCKANE</u>	13b. MOTHER'S MAIDEN NAME <u>ANNIE DAVIS</u>	14. NAME OF HUSBAND OR WIFE <u>MAGGIE MCKANE</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>	16. SOCIAL SECURITY NO. <u>490-14-7647</u>	17. INFORMANT <u>Maggie McKane, Mendon, Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Leuremia</u>		<u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Postcholecystectomy shock</u>	<u>2 days</u>
	DUE TO (c) <u>Arteriosclerotic, hypertensive heart disease</u>	<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cholelithiasis</u>		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 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 April 7 to April 13 and last saw her/him alive on April 13 1960
Death occurred at 8:35 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John Otis Carr I.O.</u>	22b. ADDRESS <u>Marceline</u>	22c. DATE SIGNED <u>4/14/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>APR 15, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>CHARITON CO., MISSOURI</u>
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24. FUNERAL DIRECTOR <u>Harold F. H., Brunswick, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-18-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beechett</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

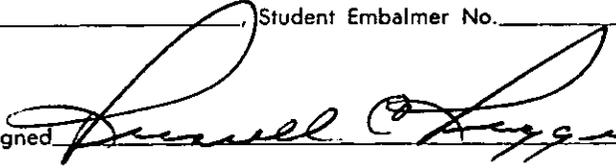
MEDICAL CERTIFICATION

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____
Licensed Embalmer No. 3792

P. O. Address  _____

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.