URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-018664

FILED VS JUN 2 1960

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 101

STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY Cass
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Harrisonville — Length of stay in 1b 1 Day.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cass
c. CITY OR TOWN Harrisonville — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 502 E Mechanic — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First THORNTON Middle L Last McCORD

4. DATE OF DEATH Month May Day 23 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH Mar 26 1909
9. AGE (last birthday) 51 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspection - Quality Control
10b. KIND OF BUSINESS OR INDUSTRY Westinghouse
11. BIRTHPLACE (City and state or country) Harrisonville Mo
12. CITIZEN OF WHAT COUNTRY U. S. A

13a. FATHER'S NAME Floyd E McCord
13b. MOTHER'S MAIDEN NAME Maurine Long
14. NAME OF HUSBAND OR WIFE Florence McCord

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO. 500-20-4247
17. INFORMANT Mrs Thornton McCord Address Harrisonville Mo

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) PULMONARY Edema Post-operative 6 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Adaption Syndrome
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rt. Inguinal Herniorrhaphy

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1948 to May 23, 1960 and last saw her/him alive on May 23, 1960
Death occurred at 3 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) O B Gargus MD
22b. ADDRESS Harrisonville Mo.
22c. DATE SIGNED May 25-1960

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE May 25 1960
23c. NAME OF CEMETERY OR CREMATORY Orient Cemetery
23d. LOCATION (City, town, or county) (State) Harrisonville Mo

24. FUNERAL DIRECTOR Runnenburgers ADDRESS Harrisonville Mo
25. DATE RECD. BY LOCAL REG. May-25-60
26. REGISTRAR'S SIGNATURE Mrs. Ray Sebree

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Ernest Rannenburg

Signature of Student Embalmer

Licensed Embalmer No. 3368

P. O. Address Harrisonv

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.