

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-018953

FILED VS JUN 6 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 127

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in 1b <u>2 da</u>	c. CITY OR TOWN <u>Washington Union</u> 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>St Francis Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR # 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>McAfee</u> Last <u>McAfee</u>			4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</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>May 28, 1960</u>	9. AGE (last birthday) <u>—</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>2</u>	IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>Washington, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>Walter Earl McAfee</u>		13b. MOTHER'S MAIDEN NAME <u>Elsie Firebaugh</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>None</u>		17. INFORMANT Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia (amniotic fluid)</u> DUE TO (b) <u>Malpresentation + Complications of delivery</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 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 <u>—</u> Month, Day, Year <u>—</u> a.m. <u>—</u> p.m. <u>—</u>			

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 <u>Washington Union, Mo</u>	COUNTY	STATE
21. I attended the deceased from <u>29 May 60</u> to <u>30 May 60</u> and last saw <u>him</u> alive on <u>30 May 60</u> Death occurred at <u>3:30</u> <u>*</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Wm R. Anderson M.D.</u>		22b. ADDRESS <u>Union, Mo</u>		22c. DATE SIGNED <u>31 May 60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 2, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eminence Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Eminence Mo</u>	

24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mountain View</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5/31/60</u>	26. REGISTRAR'S SIGNATURE <u>W. R. Anderson</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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Not Embalmed
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 *Jeanne F. Svoboda*

Licensed Embalmer No. 4507

P. O. Address Washington

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.