

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-022563**

**FILED VS JUN 30 1960**

59

Primary Registration District No. 4097

Registrar's No. 111

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cass</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville mo</u> Length of stay in 1b <u>6 weeks</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Cass</u> c. CITY OR TOWN <u>Near Cleveland mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2 miles Southeast Cleveland mo</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ORLINA</u> Middle <u>ANNA</u> Last <u>McGILL</u>			<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>15</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 28-1888</u>	<b>9. AGE</b> (last birthday) <u>72</u>	<b>IF UNDER 1 YEAR</b> Months <u>        </u> Days <u>        </u>	<b>IF UNDER 24 HR</b> Hours <u>        </u> Min. <u>        </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>House Wife</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Cleveland mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>Marion Brown</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Rona France</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Taylor McGill</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	<b>17. INFORMANT</b> <u>Mrs Helen Mill sap</u> Address <u>        </u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>        </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 MONTH</u>  <u>2 yrs</u>		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>        </u> Month, Day, Year <u>        </u> a.m. p.m.		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>8:30 p.m. June 15, 1960</u> and last saw her/him alive on <u>June 15, 1960</u> Death occurred at <u>        </u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>[Signature]</u> (Degree or title)			<b>22b. ADDRESS</b> <u>Harrisonville mo</u>		<b>22c. DATE SIGNED</b> <u>16 June 1960</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>June 17, 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Freeman mo</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Near Freeman mo</u>				
<b>24. FUNERAL DIRECTOR</b> <u>Geo. E. Myers Cleveland mo</u> ADDRESS <u>        </u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>June 17-1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs Ray Seber</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 22 1980

**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 Geo. E. Myers

Licensed Embalmer No. 25-17

P. O. Address Cleveland

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