

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023552

FILED VS. JUL 12 1960

157

Primary Registration District No.

3028

Registrar's No.

146

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Carthage</b>	Length of stay in 1b <b>49 yrs.</b>	c. CITY OR TOWN <b>Carthage</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>McCune-Brooks Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>209 No. Main</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>EVA F MCKAIN</b>			4. DATE OF DEATH Month Day Year <b>July 5 1960</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-26-95</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Osawatomie, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>James E. Featherstone</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>		14. NAME OF HUSBAND OR WIFE <b>Charles W. McKain</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Chas. W. McKain, 209 No. Main Carthage, Mo.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Metastasis from bladder</b>		<b>2 1/2 yrs</b>
	DUE TO (c)		

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	
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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 Month, Day, Year a.m. p.m.	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 **2/25/47** to **7/5/60** and last saw her alive on **7-5-60**  
Death occurred at **2:00 P** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>W. F. Foster, M.D.</b>	22b. ADDRESS <b>Carthage, Mo.</b>	22c. DATE SIGNED <b>7-6-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>7-7-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Carthage, Missouri</b>
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24. FUNERAL DIRECTOR <b>Knell Mortuary, Carthage, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-6-60</b>	26. REGISTRAR'S SIGNATURE <b>W. F. Foster</b>
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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 Robert H Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

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.