

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026517

FILED JUL 25 1960

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 720

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>20 Yrs.</b>	c. CITY OR TOWN <b>SPRINGFIELD</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>ST. JOHN'S HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2049 BENTON</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>NIVES</b> Last <b>McNERNEY</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>1960</b>		
5. SEX <b>MALE</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>8/1/86</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>	11. BIRTHPLACE (City and state or country) <b>VERONA, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>PATRICK McNERNEY</b>		13b. MOTHER'S MAIDEN NAME <b>MARY ANN BAINBRIDGE</b>		14. NAME OF HUSBAND OR WIFE <b>ELLA A. McNERNEY</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>494-18-0046</b>	17. INFORMANT Address <b>MRS. ELLA A. McNERNEY, SPRINGFIELD, 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>Coronary Artery Disease (Infarction)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>?</b>
DUE TO (c) <b>Generalized Arteriosclerosis</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetic + Arteriosclerotic gangrene - Left Leg</b>		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 checked="" 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 <b>SPRINGFIELD</b>	COUNTY <b>GREENE</b>	STATE <b>MISSOURI</b>
21. I attended the deceased from <b>5/30/57</b> to <b>7/14/60</b> and last saw <sup>her</sup> him alive on <b>7/14/60</b> . Death occurred at <b>5:10 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Dee or title) <b>Harold H. Lurie, M.D.</b>		22b. ADDRESS <b>609 Cherry Springfield, Mo.</b>		22c. DATE SIGNED <b>7/15/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7/18/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>AURORA, MISSOURI</b>

24. FUNERAL DIRECTOR ADDRESS <b>H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>7-18-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</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 W. L. McCann

Licensed Embalmer No. 272

P. O. Address W. L. McCann

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.