

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

=60-027224
STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 4246 Registrar's No. 124

ENDED

1. PLACE OF DEATH a. COUNTY <u>Jasper</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carl Junction, Mo.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>404 S. Main St.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u> c. CITY OR TOWN <u>Carl Junction, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>404 S. Main St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in 1b <u>6 Years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>McCreary</u>			4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </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>Store owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (City and state or country) <u>Rome, Ga.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John McCreary</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Gibbs</u>		14. NAME OF HUSBAND OR WIFE <u>Anna McCreary</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.		17. INFORMANT Address <u>Anna McCreary</u>			

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>Toxemia, hyperpyrexia</u> DUE TO (b) <u>Gangrene, Rt. foot</u> DUE TO (c) <u>Obliterative arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 year</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>		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 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 <u> </u> Month, Day, Year <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		COUNTY		STATE	

21. I attended the deceased from July 1, 1955 to and last saw him alive on July 27, 1960
 Death occurred at 10:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Leah H. Jones, MD</u> (Degree or title)		22b. ADDRESS <u>Columbus, Kansas</u>					
22c. DATE/SIGNED <u>8/1/60</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)	
<u>Burial</u>		<u>7-30-1960</u>		<u>Carl Junction, Mo.</u>		<u>Carl Junction, Mo.</u>	
24. FUNERAL DIRECTOR <u>Don Roney, Carl Junction, Mo.</u>		25. DATE RECD BY LOCAL REG. <u>8-2-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Madeline Switzer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 9 1960

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 Blayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City

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.