

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029722

FILED VS. SEP 12 1960 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 927

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in lb Lifetime c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) 1802 S. 37th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margie Middle McCarthy Last McCarthy			4. DATE OF DEATH Month August Day 26 Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1921	9. AGE (last birthday) 39	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) St. Joseph, Missouri.			
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Cleo Johnson		13b. MOTHER'S MAIDEN NAME Ethel Elam			
14. NAME OF HUSBAND OR WIFE Thomas McCarthy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none			
17. INFORMANT Thomas McCarthy		Address St. Joseph, Mo.					
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>Uremia</u> DUE TO (b) <u>Congenital polycystic renal disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>life</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Hypertensive heart disease with heart failure</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 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 COUNTY STATE			
21. I attended the deceased from <u>9/24/59</u> to <u>8/26/60</u> and last saw her alive on <u>8/25/60</u> Death occurred at <u>8:25 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Donald J. Stallard, M.D.</u>			22b. ADDRESS <u>902 Edmond St.</u>		22c. DATE SIGNED <u>9/2/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE <u>Aug. 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.			
24. FUNERAL DIRECTOR ADDRESS <u>Meierhoffer-Fleeman, Inc.</u> St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. <u>Sept. 6, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>		

DOCUMENT

D.J. Stallard, M.D. Medical Certification

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

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 Albert R. Harrington

Licensed Embalmer No. 2258

P. O. Address H. Joseph

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.