-60-031601

RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

LED VS AUG 31 1960

STATE FILE NUMBER

Registration District No. 277 Primary Registration District No. 4411 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY: PIKE	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MO. b. COUNTY: PIKE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: BOWLING GREEN, MO. Length of stay in 1b: —	c. CITY OR TOWN: BOWLING GREEN Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: — Inside Limits: Yes ☐ No ☐	d. STREET ADDRESS (If outside, give location): 16 S. SCIENCE ST. Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print)	First: DAISY	Middle: MAE	Last: McCLEERY	4. DATE OF DEATH	Month: Aug. Day: 25 Year: 1960
5. SEX: F	6. COLOR OR RACE: W	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH: 4-5-1878	9. AGE (last birthday): 82	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE	10b. KIND OF BUSINESS OR INDUSTRY: —	11. BIRTHPLACE (City and state or country): MIDDLETOWN, MO.	12. CITIZEN OF WHAT COUNTRY: U.S.A.		
13a. FATHER'S NAME: RUBIN KISNER	13b. MOTHER'S MAIDEN NAME: KATHRENE LONG	14. NAME OF HUSBAND OR WIFE: SAMUAL McCLEERY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: —	17. INFORMANT: MRS. KATHRENE MENEFEE	Address: VANDALIA, 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): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Auricular Tachycardia

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Aug. 5, 1960 to Aug. 25, 1960 and last saw her alive on Aug. 22, 1960

Death occurred at 7 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] D.O.	22b. ADDRESS: 214 W. Church, Bowling Green, Mo.	22c. DATE SIGNED: 8/26/60	
23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)	23b. DATE: 8-27-60	23c. NAME OF CEMETERY OR CREMATORY: BOWLING GREEN	23d. LOCATION (City, town, or county) (State): BOWLING GREEN, MO.
24. FUNERAL DIRECTOR — ADDRESS: BANKHEAD FUNERAL CHAPEL	25. DATE RECD. BY LOCAL REG.: AUG. 27, 1960	26. REGISTRAR'S SIGNATURE: Maidee E. Williams	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____ Signed Harold Kirks

Signature of Student Embalmer

Licensed Embalmer No. 4597

P. O. Address Bowling G

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