

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-033468

STATE FILE NUMBER

FILED VS SEP 12 1960

Registration District No. 325

Primary Registration District No. 4480

Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <i>Schuyler</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Schuyler</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Greentop</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Glenwood</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>90</i>		Length of stay in lb <i>2 or 3 hrs</i>	d. STREET ADDRESS (If outside, give location) <i>0980</i> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>None</i> Last <i>McCartney</i>			4. DATE OF DEATH Month <i>Sept</i> Day <i>1</i> Year <i>1960</i>				
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 9 1874</i>		9. AGE (In years last birthday) <i>85</i>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Bucklin Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13a. FATHER'S NAME <i>David McCartney</i>			13b. MOTHER'S MAIDEN NAME <i>Ellen Lucas</i>		14. NAME OF HUSBAND OR WIFE <i>None</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Walter McCartney</i> Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>medullary infarct due to anemia</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>bronchial pneumonia</i>		
	DUE TO (c) <i>prolonged bed rest 331X</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Cerebral vascular accident</i>			19. WAS AUTOPSY PERFORMED? c. 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Death occurred at <i>10:30 P</i>		to <i>9-1-60</i>		and last saw him alive on <i>9-1-60</i>			
22a. SIGNATURE <i>Frank D. ...</i> (Degree or title)		22b. ADDRESS <i>Greentop Mo</i>		22c. DATE SIGNED <i>9-3-60</i>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Sept 4 '60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cemetery (rural)</i>		23d. LOCATION (City, town, or county) (State) <i>Queen City Mo</i>		
24. FUNERAL DIRECTOR <i>Dorley Inrl Home</i>			ADDRESS <i>Queen City Mo</i>		25. DATE RECD. BY LOCAL REG. <i>9-8-60</i>	26. REGISTRAR'S SIGNATURE <i>Wm. A. ...</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Jack H. Stroh* .....  
Licensed Embalmer, No. .... *4619*

P. O. Address .. *Quincy, Mo*

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.