URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-037267

FILED VS OCT 3 1960

NDED

Registration District No. 323 Primary Registration District No. 45745 Registrar's No. 46

STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY WEBSTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD
Length of stay in Ib 6 HRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY WEBSTER
c. CITY OR TOWN MARSHFIELD Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 722 COMMERCIAL (If outside, give location) Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First CAROLYN Middle JOY Last MCVAY
4. DATE OF DEATH Month SEPT Day 19 Year 1960
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 5-1-1939
9. AGE (last birthday) 21
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) MOTHERS HELPER
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) MISSOURI
12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME CLAY MCVAY
13b. MOTHER'S MAIDEN NAME FRIIDA HUBBARD
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT CLAY MCVAY Address MARSHFIELD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Suffocation — INTERVAL BETWEEN ONSET AND DEATH 3 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) aspiration of Vomitus — 3 min
DUE TO (c) Convulsion, Epilepsy — 3-4 min, 4 years
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

BY AFFIDAVIT OF

21. I attended the deceased from 8/3/55 to 8/19/60 and last saw ~~him~~ her alive on 8/27/60.
Death occurred at between 2 and 3 ~~a.m.~~ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE T. M. Macdonnell (Degree or title) MD
22b. ADDRESS Marshfield, Mo
22c. DATE SIGNED 22 Sept 60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 9-21-1960
23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD
23d. LOCATION (City, town, or county) MARSHFIELD (State) MO
24. FUNERAL DIRECTOR BARBER-EDWARDS ADDRESS MARSHFIELD
25. DATE RECD. BY LOCAL REG. 9-24-60
26. REGISTRAR'S SIGNATURE J. Francis

(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_____ Signed George Stapp

Signature of Student Embalmer

Licensed Embalmer No. 5 1-6

P. O. Address Mt. Ave

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.