

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037548

FILED VS OCT 24 1960

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STATE FILE NUMBER

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

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY		BUCHANAN		a. STATE		MISSOURI	
b. CITY (If outside corporate limits, give TOWNSHIP only)		ST. JOSEPH		b. COUNTY		BUCHANAN	
OR TOWN		ST. JOSEPH		c. CITY OR TOWN		ST. JOSEPH	
Length of stay in 1b		2 yrs		c. CITY OR TOWN		ST. JOSEPH	
c. FULL NAME OF (If NOT in hospital, give location)		2515 North Fourth		d. STREET ADDRESS		2515 North Fourth	
HOSPITAL OR INSTITUTION		2515 North Fourth		(If outside, give location)		2515 North Fourth	
Inside Limits		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First		Middle		Last		Month Day Year	
NOAH		ANDERSON		McCAULEY		October 14, 1960	
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
male		white				3-1-81	
9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
79		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
retired farmer				own farm		Buchanan County, Mo. U S A	
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Samuel McCauley				Adalion Harness		Odie McCauley	
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 Address	
no				487-42-7079		Mrs. Crystal Brown 2515 N 4th 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) <i>Leukemia - Chronic Lymphatic</i>							
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							
<i>Anemia due to Leukemia</i>							
PART III. If deceased was female was there a pregnancy in last 90 days.							
<input type="checkbox"/> Yes <input type="checkbox"/> N <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 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 <i>9-24-57</i> to <i>10-14-60</i> and last saw him alive on <i>10-14-60</i>							
Death occurred at <i>9:09 PM</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title)				22b. ADDRESS		22c. DATE SIGNED	
<i>H.C. Senne MD.</i>				<i>223 N 7th St. Joseph, Mo</i>		<i>10-17-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
removal		10-14-60		Sparta Cemetery		Buchanan County, Mo.	
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
BREIT & HAWKINS SAVANNAH				Oct. 18, 1960		<i>Mrs. Clark Goodell</i>	

DOCUMENT

H.C. Senne MD MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 James B. Hawken

Licensed Embalmer No. 4531

P. O. Address Severn

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.