

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045589

FILED VS DEC 19 1960

Registration District No. 100 Primary Registration District No. _____ Registrar's No. 100 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springcreek Twp.</u>		Length of stay in 1b <u>13</u> years		c. CITY OR TOWN <u>Salem</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence approx. 2 Mi. No. of Salem, Mo</u>				d. STREET ADDRESS (If outside, give location) <u>Route 4</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALVA</u> Middle <u>ERNEST</u> Last <u>McDONALD</u>			4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/5/1882</u>	9. AGE (last birthday) <u>78</u>	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) <u>Farmer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Dent County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John W. McDonald</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah J. Blackwell</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Edna Leohard Salem, Mo.</u>			
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>CHRONIC MYOCARDITIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12/12/60</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <u>CHRONIC COLITIS</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 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 <u>1/24/58</u> to <u>12/12/60</u> and last saw ^{her} him alive on <u>12/12/60</u> Death occurred at <u>10:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>A. H. Hunt M.D.</u>				22b. ADDRESS <u>5 HALEY - 140</u>		22c. DATE SIGNED <u>12/16/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/16/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blackwell Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Dent County, Missouri</u>		
24. FUNERAL DIRECTOR <u>Wesley P. [unclear]</u>			ADDRESS <u>Salem, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12/16/60</u>	26. REGISTRAR'S SIGNATURE <u>M. M. Hart, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 20 1960

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 JAMES E. KURTTRIGHT, Student Embalmer No. 611

working under my personal supervision.

Student James E. Kurttright
Signature of Student Embalmer

Signed Max L. Crawford

Licensed Embalmer No. 4170

P. O. Address Salem,

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.