

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024151

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042 Primary Registration District No. 1000 Registrar's No. 774

STATE FILE NUMBER

AMENDED

FILED AUG 7 1961

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>86yrs</b>	c. CITY OR TOWN <b>St. Joseph,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>428 Virginia</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Pearl</b> Last <b>McCain</b>			4. DATE OF DEATH Month <b>Aug</b> Day <b>2</b> Year <b>1961</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1875</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Indiana</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>James P. McCain</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Jane Cox</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Gladys Davis, St. Joseph, Mo</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchpneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>Chronic</b>
DUE TO (c) <b>Diabetes Mellitus</b>		<b>Chronic</b>
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. <input type="checkbox"/> Yes <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **8/1/61** to **8/2/61** and last saw her/him alive on **8/1/61**  
Death occurred at **7:42 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>G.E. Cozzins M.D.</b>	22b. ADDRESS <b>State Hospit #2 St. Joseph, Mo</b>	22c. DATE SIGNED <b>8/2/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/3/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethle Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>DeKalb, Mo</b>
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24. FUNERAL DIRECTOR <b>John E. Ruppert</b>	ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Aug 3, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mar. Clark Stoddell</b>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

C.E. Cozzins, M.D. 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 me,

~~or~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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.