

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036716

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 112

FILED NOV 7 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Howard</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fayette</u>	a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Length of stay in lb <u>2 months</u>		c. CITY OR TOWN <u>Fayette</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shields Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>405 Oaklawn</u>	

3. NAME OF DECEASED (Type or print)	First <u>HARRY</u>	Middle <u>ERICKSON</u>	Last <u>MC CRARY</u>	4. DATE OF DEATH	Month <u>Oct.</u>	Day <u>29,</u>	Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/1877</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____	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) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (City and state or country) <u>Howard Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William Gilpin McCrary</u>	13b. MOTHER'S MAIDEN NAME <u>Emma B. Erickson</u>	14. NAME OF HUSBAND OR WIFE <u>Mattie Carter</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs Harry McCrary</u> Address <u>Fayette, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized.</u>	<u>1 year.</u>
DUE TO (b) <u>Parkinson's Syndrome</u>	<u>5 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition stated in PART I (a) <u>Chronic Urinary disease</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
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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 <u>Fayette Mo, 1946</u> to <u>10/29/61</u> and last saw him <u>10/29/61</u> ^{was} alive on _____	Death occurred at <u>Fayette Mo, 3: P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Wm G Shaw, M.D.</u> (Degree or title)	22b. ADDRESS <u>Fayette, Mo.</u>	22c. DATE SIGNED <u>10/30/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/31/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>	23d. LOCATION (City, town, or county) <u>Glasgow, Missouri</u>
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24. FUNERAL DIRECTOR <u>Salud A. Carr</u> ADDRESS <u>Fayette, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>10-30-61</u>	26. REGISTRAR'S SIGNATURE <u>Katherine Welch</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

JUN 7 1962

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 Ralph A. Case

Licensed Embalmer No. 3340

P. O. Address Fayette, 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.