

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=62-002651**

STATE FILE NUMBER

AMENDED

Registration District No. 195 Primary Registration District No. \_\_\_\_\_ Registrar's No. 7-62

**FILED JAN 30 1962**

1. PLACE OF DEATH a. COUNTY <b>McDonald</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>McDonald</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Noel</b>		Length of stay in 1b <b>30 years</b>	c. CITY OR TOWN <b>Noel</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>			d. STREET ADDRESS (If outside, give location) <b>Rt. # 3</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Conway</b> Middle <b>Walter</b> Last <b>McMahan</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>19,</b> Year <b>1962</b>			
5. SEX <b>Male</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>1-21-29</b>	9. AGE (last birthday) <b>32</b>	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) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>	11. BIRTHPLACE (City and state or country) <b>Mt. View, Ark.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Mihes W. McMahan</b>		13b. MOTHER'S MAIDEN NAME <b>Elsie/Ekevene (deceased)</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			17. INFORMANT Address <b>Bonnie Stillions, Noel, Mo.</b>			
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>Cerebral Hemorrhage</b> <b>Investigated By R.M. Humphrey Jr. Coroner</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</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 type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>NOEL, MO.</b>		COUNTY _____ STATE _____	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at <b>9:00 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Mary A. Bradley Registrar</b>			22b. ADDRESS <b>PINEVILLE, Mo. 65001</b>		22c. DATE SIGNED <b>1-22-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-22-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Noel Cemetery</b>	23d. LOCATION (City, town, or county) <b>Noel, Mo.</b>		(State) _____	
24. FUNERAL DIRECTOR <b>Humphrey Funeral Home, Noel, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>1-22-62</b>	26. REGISTRAR'S SIGNATURE <b>Mary A. Bradley</b>		

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 5 1962

30 YEARS

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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 Wayne A. Hubbard

Licensed Embalmer No. 5172

P. O. Address Rock, 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.

Bureau of Health & Sanitation

Department of Health & Sanitation

1-22-62