

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035562

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 227 STATE FILE NUMBER 207

FILED OCT 8 1962

1. PLACE OF DEATH a. COUNTY <u>NODAWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>NODAWAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SHERIDON</u>		Length of stay in 1b <u>32 yrs</u>	c. CITY OR TOWN <u>SHERIDON</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>Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD -</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLEY F. McKEE</u>			4. DATE OF DEATH Month Day Year <u>9-24-1962</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</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>3-4-1892</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HR <input checked="" type="checkbox"/> Months Days Hours Min.
10. 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>FARMING</u>		11. BIRTHPLACE (City, and state or country) <u>PICKERING, Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>W.R. McKEE</u>		13b. MOTHER'S MAIDEN NAME <u>MARY JONES</u>	
14. NAME OF HUSBAND OR WIFE <u>BERYL McKEE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give unit or dates of serv)		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>Mrs Beryl McKEE - Sheridan Mo</u>		Address			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Bronchitic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Spinal Metastases</u>		
DUE TO (c)		

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	
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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.)	
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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>1957</u> to <u>1962</u>	COUNTY <u>Mo</u>	STATE
21. I attended the deceased from <u>8 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Glenn M. [Signature]</u> (Degree or title)		22b. ADDRESS <u>Maryville Mo</u>	22c. DATE SIGNED <u>10/1/62</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-27-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Oak Cem - Pickering Mo.</u>	23d. LOCATION (City, town, or county)
24. FUNERAL DIRECTOR <u>Hitchison - Maryville Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-1-62</u>	26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>

VS 300 Rev. 4/59
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
SHOULD READ
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 George M. Otkhior

Licensed Embalmer No. 5114

P. O. Address Maryville 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.

Handwritten scribbles at the bottom of the page.