

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004766

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 14

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 4 1963						
1. PLACE OF DEATH a. COUNTY Saline b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall Length of stay in 1b 5 years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Fitzgibbon Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline c. CITY OR TOWN Marshall Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 585 West Jackson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First Middle Last KATHLEEN PEARL McRADY						
4. DATE OF DEATH Month Day Year January 25, 1963						
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-23-1887	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Saline County, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME A. G. Ballard		13b. MOTHER'S MAIDEN NAME Sarah E. Schooling		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Alta Robinson, Gilliam, Mo.		
18. CAUSE OF DEATH (Enter only one cause)		INTERVAL BETWEEN ONSET AND DEATH 10 days				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		Hypertension				
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)				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 <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 12-27-63 to 1-25-63 and last saw her ^{her} _{him} alive on Jan 25 1963 Death occurred at 5:10 pm. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>[Signature]</i>		22b. ADDRESS Marshall Mo		22c. DATE SIGNED 1/26/63		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-28-1963	23c. NAME OF CEMETERY OR CREMATORY Arrow Rock Cemetery		23d. LOCATION (City, town, or county) (State) Arrow Rock, Missouri		
24. FUNERAL DIRECTOR ADDRESS Campbell & Lewis Marshall, Mo.		25. DATE RECD. BY LOCAL REG. 1-28-'63	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
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 *James H. Lewis Jr.*

Licensed Embalmer No. 4709

P. O. Address Marshall, 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.