

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No.

No. 300
10-48

FILED JAN 16 1950

State File No.

28

BIRTH NO. _____		REG. DIST. NO. <u>87</u>		PRIMARY REG. DIST. NO. <u>5324</u>		Registrar's No. <u>12</u>			
1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>				2. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL-BOONE TWP.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		d. STREET ADDRESS (If rural, give location) <u>1207 TOWER GRAVE AVE.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____					
3. NAME OF DECEASED (Type or Print) a. (First) <u>RADIUS</u>			b. (Middle) <u>Z.</u>		c. (Last) <u>McCoy</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12-18-1949.</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>SEPT. 4, 1913</u>		9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) <u>36 3 14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired) <u>LABORER (WELDER)</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>CRAWFORD Co., MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>PATRICK J. McCoy</u>			13b. MOTHER'S MAIDEN NAME <u>ELSIE FOWLER</u>			14. NAME OF HUSBAND OR WIFE <u>DOROTHY McCoy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>484-03-4321</u>		17. INFORMANT'S SIGNATURE OR NAME <u>PATRICK McCoy - 1207 TOWER GRAVE ST. LOUIS, MO.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Instant death caused by automobile collision</u>						INTERVAL BETWEEN ONSET AND DEATH <u>ES 166</u> <u># 26</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Boone Township, Crawford Co., Mo.</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>Dec. 18 1949 6:10 P.M.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile Collision</u>					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Paul A. Frank</u> (Degree or title) _____				23b. ADDRESS <u>Cuba, Mo.</u>				23c. DATE SIGNED <u>12-20-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>12-21-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>STEELVILLE CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>STEELVILLE, MO.</u>			
DATE REC'D BY LOCAL REG. <u>12/31/49</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		75		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>THOMAS S. HALBERT - STEELVILLE, MO.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 17 1950

RECEIVED 1/7/50

District Health Officer No. 5,

District File Number 15023

Date Filed 1/13/50

FEB 18 1950

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.

Signed

Norman C. Hoener

Signed _____

Student Embalmer

Licensed Embalmer No. 4673

P. O. Address Cuba 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 this body is not embalmed, fact should be so stated above.