

Health,
& Welfare
Public
Service

FILED SEP 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28097

STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 161

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Grundy</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lenton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Humphreys</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If in hospital or institution) <u>Wilfred Mucky</u>		Length of stay in lb <u>10 da</u>	d. STREET ADDRESS (If outside, give location) <u>50</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Obbie</u> Middle <u>May</u> Last <u>Mucky</u>			4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1957</u>			
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5. SEX <u>f</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-7-1868</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Grundy Co. mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Allan Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Couchick</u>	14. NAME OF HUSBAND OR WIFE <u>George Mucky</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)	16. SOCIAL SECURITY NO. <u>L</u>	17. INFORMANT <u>Allan Mucky</u> Address <u>Humphreys mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 da</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Atherosclerosis.</u>	<u>?</u>
	DUE TO (c) _____	<u>331X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.	20d. INJURY OCCURRED WHILE AT <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 <u>Humphreys</u>	COUNTY <u>mo</u>	STATE <u>mo</u>
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21. I attended the deceased from <u>8-28-57</u> to <u>9-2-57</u> and last saw her alive on <u>8-28-57</u> Death occurred at <u>4:45 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>U.C. West</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Holt, Mo.</u>	22c. DATE SIGNED <u>9-3-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-5-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Humphreys Cem.</u>	23d. LOCATION (City, town, or county) <u>Humphreys</u>	(State) <u>mo</u>
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24. FUNERAL DIRECTOR <u>Dr Payne</u> ADDRESS <u>Salt Mo</u>	25. DATE RECD. BY LOCAL REG. <u>9-4-57</u>	26. REGISTRAR'S SIGNATURE <u>Drene Jaiw</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *PK Payne Jr*

Licensed Embalmer No. *3400*

P. O. Address *Galt*

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.