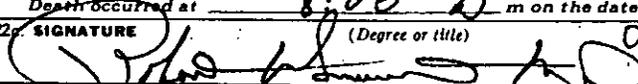


FILED SEP 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28667  
STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 264

1. PLACE OF DEATH a. COUNTY <b>LINN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>LINN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MARCELINE</b>		c. CITY OR TOWN <b>MARCELINE</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Francis Hosp</b>		d. STREET ADDRESS <b>341 W. MARCELINE</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>MCGEE</b> Last <b>OTHIE</b>		4. DATE OF DEATH Month <b>AUG</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 8 1886</b>
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>FARM</b>	11. BIRTHPLACE (City and state or country) <b>Chariton Co. Mo.</b>
13. FATHER'S NAME <b>PALED OTHIE</b>		14. MOTHER'S MAIDEN NAME <b>MARY ANN MCINTIRE</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>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT <b>F-K Tullation, Marceline 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>Crownary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>4200</b>			INTERVAL BETWEEN ONSET AND DEATH
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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
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 _____ 1953 8-21-57 and last saw her alive on 8-21-57 Death occurred at 8:00 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE 		22b. ADDRESS <b>Marceline, Mo</b>	22c. DATE SIGNED <b>8-21-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8-23-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. KILLIARD</b>	23d. LOCATION (City, town, or county) (State) <b>MARCELINE Mo</b>
24. FUNERAL DIRECTOR <b>MILLER-Tilbottson</b>		25. DATE RECD. BY LOCAL REG. <b>8-22-57</b>	26. REGISTRAR'S SIGNATURE <b>Broonie Owens</b>

AUG 11 1958

SEP 18 1957

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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 *William K. Tella* .....

Licensed Embalmer No. *25*

P. O. Address *Mare* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.