

Dept. Health,  
& Welfare  
U. S. Public  
Health Service

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47011  
STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 3075 Registrar's No. 2

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dexter</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Dexter</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>110 Matthews</u>		Length of stay in lb <u>12 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>110 Matthews</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Everett</u> Middle <u>NMI</u> Last <u>McRoy</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1899</u>
9. AGE (In years from birthday) <u>58</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>	11. BIRTHPLACE (City and state or country) <u>Bloomfield, Mo.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Bill McRoy</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Durdin</u>	14. NAME OF HUSBAND OR WIFE <u>Elsie McRoy</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>498-10-5923</u>	17. INFORMANT <u>Carl McRoy</u> Address <u>Dexter, Mo.</u>
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>pulmonary edema</u> DUE TO (b) <u>Cardiac failure</u> DUE TO (c) <u>arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>
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.	
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		COUNTY STATE	
21. I attended the deceased from <u>11/29/57</u> to <u>12/11/57</u> and last saw him alive on <u>12/11/57</u> Death occurred at <u>10:30</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William J. Turner MD</u> (Degree or title)		22b. ADDRESS <u>Dexter, Mo.</u>	22c. DATE SIGNED <u>12/14/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>12-13-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walker cemetery</u>
23d. LOCATION (City, town, or county) <u>Bloomfield, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Watkins &amp; Sons</u> ADDRESS <u>Dexter, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-16-57</u>	26. REGISTRAR'S SIGNATURE <u>Delma V Jenkins</u>

securing the medical certification in the specific manner required by 191.140 MoRS 1949.  
 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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 *Marshall H. Hines* .....

Licensed Embalmer No. *4717* .....

P. O. Address *Center 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.