

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000086
STATE FILE NUMBER

S. 300
1-57

FILED FEB 13 1959 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY <i>Andrain</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Andrain</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Mexico</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Centralia</i> 00 40 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Andrain County Hospital</i>		Length of stay in 1b <i>35 days.</i>	d. STREET ADDRESS (If outside, give location) <i>R. F. D. # 2</i>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <i>Carl</i> Middle <i>Walter</i> Last <i>Mc Coy</i>			4. DATE OF DEATH Month <i>Feb</i> Day <i>5</i> Year <i>1959</i>	
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>March 18-1895</i>	9. AGE (In years last birthday) <i>63</i>	IF UNDER 1 YEAR Months <i>10</i> Days <i>13</i>	IF UNDER 24 HR Hours <i>13</i> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpet Layer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Carpet Layer</i>	11. BIRTHPLACE (City and state or country) <i>Andrain Co. Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13a. FATHER'S NAME <i>Alfred B. Mc Coy</i>	13b. MOTHER'S MAIDEN NAME <i>Alice N. Davis</i>	14. NAME OF HUSBAND OR WIFE <i>—</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <i>yes W.W.I</i>	16. SOCIAL SECURITY NO. <i>443-03-8281</i>	17. INFORMANT <i>O. G. Mc Coy, Centralia, Mo.</i>	Address
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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) <i>Carcinoma of lung with Metastatic spread to Brain</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <i>Carcinoma of Glans Penis</i>		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.) <i>—</i>
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20c. TIME OF INJURY Hour _____ 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.) <i>—</i>	20f. CITY, TOWN, OR LOCATION <i>Centralia</i>	COUNTY <i>MO</i>	STATE <i>MO</i>
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21. I attended the deceased from *12/29/58* to *1/5/59* and last saw him alive on *1/5/59*
Death occurred at *6:50 p* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Robt L. Wood MD</i>	22b. ADDRESS <i>Centralia MO</i>	22c. DATE SIGNED <i>1/7/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Feb. 8-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Salt River Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Andrain County, Mo.</i>
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24. FUNERAL DIRECTOR <i>Paul Q. Ballou, Centralia, Mo.</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>Feb 7-1959</i>	26. REGISTRAR'S SIGNATURE <i>Blanche Reely</i>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diagnoses in Part I must be carefully related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. MEDICAL CERTIFICATION. Robert L. Wood, M.D.

FEB 17 1959

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 *Paul J. Baller*

Licensed Embalmer No. *4206*
P. O. Address *Centrodia*

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.