

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0050823

7011

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 17 1964

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE Kansas b. COUNTY allen.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 10 days	c. CITY OR TOWN Iola
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 507 So. Jefferson
3. NAME OF DECEASED (Type or print) CHARLES MC CANN		4. DATE OF DEATH Month December Day 26 Year 1963	

5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-9-1888		9. AGE (last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker				10b. KIND OF BUSINESS OR INDUSTRY Allen County Bank		11. BIRTHPLACE (City and state or country) Allen County, Kansas				12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME James McCann				13b. MOTHER'S MAIDEN NAME Sarah McMahon				14. NAME OF HUSBAND OR WIFE Mary Murphy McCann							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. [REDACTED]				17. INFORMANT Miss Mary McCann 640 E. Armour				Address			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Hypostatic pneumonia										72 hrs			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease										10 yrs			
DUE TO (c)													

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture, femur, neck, left								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Pt fell at home					
20c. TIME OF INJURY 6:00 p.m.		Hour Month, Day, Year 12/15/63							

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION Iola		COUNTY Tanana		STATE	
21. I attended the deceased from 12-16-63 to 12-25-63 and last saw him alive on 12-25-63 Death occurred at St. Luke's Hosp, 2nd fl. on the date stated above, and to the best of my knowledge, from the causes stated.									

22a. SIGNATURE (Degree or title) Paul W. Meyer M.D.				22b. ADDRESS 4312 J.C. Nichols Hwy				22c. DATE SIGNED 12/26/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-26-63		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		23d. LOCATION (City, town, or county) Iola, Kansas		(State)	

24. FUNERAL DIRECTOR Melody-McGilley-Eylar 20 W. Linwood		ADDRESS		25. DATE RECD. BY LOCAL REG. 12-26-63		26. REGISTRAR'S SIGNATURE Bessie Smith	
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DATE AMENDED
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF
 Paul W. Meyer

VS 300 Rev. 4/59	
1	
2 8450	
3	
4 0	
5 2	
6	
7 1	
8 2	
9/200F	
10	
11	
12 66-0	
13	

USE BLACK INK OR TYPEWRITER RIBBON

8230803

Mr Frank Mickson
4312 J C Nichols
J 1-5757

Thurs. - until 1:00

Signed

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 James E. Hackleman

Licensed Embalmer No. 4573

P. O. Address J C Nichols

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.