

FILED AUG 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28672

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 6178 Registrar's No. 327

1. PLACE OF DEATH a. COUNTY SHANNON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY City St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EMINENCE		c. LENGTH OF STAY (in this place) 2 yrs	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION		4. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) SAMUEL b. (Middle) THEARRON c. (Last) McROY		4. DATE OF DEATH (Month) (Day) (Year) Aug. 11-1955	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Oct. 9-1904
9. AGE (In years last birthday) 30		10. UNDER 1 YEAR Months 10	11. UNDER 2 HRS. Hours 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY Grocer Co.	11. BIRTHPLACE (City and State or Foreign Country) SACRAMENTO, KY.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Samuel McRoy	13b. MOTHER'S MAIDEN NAME ESPIE KEY
14. NAME OF HUSBAND OR WIFE MARIE McROY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME MARIE McROY		18. ADDRESS 924 LAMI St. Louis, Mo.	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Stomach ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 151X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 10, 1955, to Aug 1, 1955, that I last saw the deceased alive on Aug 1, 1955, and that death occurred at 11:20 P.M., from the causes and on the date stated above.			
23a. SIGNATURE R. D. Kallin M.D.		23b. ADDRESS Winona Mo.	
23c. DATE SIGNED Aug 13-55		23d. DATE	
24a. BURIAL, CREMATION, REMOVAL (Specify) B		24b. DATE Aug. 13-55	
24c. NAME OF CEMETERY OR CREMATORY Powell		24d. LOCATION (City, town, or county) (State) Eminence, Mo.	
DATE REC'D BY LOCAL REG. 8-22-55		REGISTRAR'S SIGNATURE 447-0	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS DUNCAN'S Mt. View, Mo.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 23 1955

OCT 1955

NOV 1 1955

JAN 23 1958

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 *Joe R. Sumner*..... Licensed Embalmer No. 432

P. O. Address *Mt. View*.....

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.