

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

30 1928

31127

1. PLACE OF DEATH

County Mississippi

Registration District No. 569

Township Ohio

Primary Registration District No. 5745

City Bridgesport (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

2. FULL NAME

George McClain

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS about 80 If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY) Unknown

14. INFORMANT a woodruff  
(Address) Charleston Mo 74

15. FILED 9/27/28 19\_\_\_\_ REGISTRAR Charleston

3 MEDICAL CERTIFICATE OF DEATH 12:10 PM

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-26 1928

17. I HEREBY CERTIFY That I attended deceased from 9/10 1928, to 9/26 1928 that I last saw alive on 9/21/28, 1928, and that death occurred, on the date stated above, at noon

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Stroke and Cerebral Degeneracy

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED no

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) E. J. Howell, M. D.

926, 1928 (Address) Wyatt Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Rushes Ridge 9/27 1928

20. UNDERTAKER ADDRESS

Lane and Co Charleston Mo

The item of information is carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH. County Missouri Registration District No. 269 File No. ....  
 Township Chico Primary Registration District No. 3763 Registered No. ....  
 City (No. ....) St. .... Ward) .....

2. FULL NAME Frank Mc Clain  
 (a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)

5A.  MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-26-28 19 28

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw him alive on ..... 19..... and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Depression & General Debility  
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Intestinal Neoplasia  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 129a  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....  
 WHAT TEST CONFIRMED DIAGNOSIS?.....  
 (Signed)..... M. D.  
 , 19 (Address)

**SUPPLEMENTARY**

14. INFORMANT (Address) .....

15. FILED 28 Adm. Marshall REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....  
 ADDRESS .....

20. UNDERTAKER ADDRESS .....

B. Every item of information should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, & should be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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