

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

Do not use this space.

B3737

1. PLACE OF DEATH

County Johnson Registration District No. 1002 File No. _____
 Township W. C. 2nd Primary Registration District No. _____ Registered No. 4189
 City W. C. 2nd (No. 2823) Nabash, Ave, St. _____ Ward _____

2. FULL NAME

Birdie Marie Mc Clellan
 (a) Residence. No. Dade Co. 2nd 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Mc Clellan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-25-1904
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
24 11 14

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At Home
 (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 Melvin Leuber
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Michigan
 12. MAIDEN NAME OF MOTHER Mrs. O. O. Smith
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Kansas

14. INFORMANT Mrs. Maudie Haller
 (Address) 2823 Nabash, Ave

15. FILED 10/9/29 M. M. Crowe REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-9-1929
 17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1929, to Oct 9, 1929
 That I last saw him alive on Oct 8 11:30 pm, 1929, and that death occurred on the date stated above, at 2:30 AM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
139B
122B
Cardiogenic Ebers
 (duration) yrs. mos. ds. 4
 CONTRIBUTORY Pulvis abscess - Right
 (SECONDARY) Paposeptis
 (duration) yrs. mos. ds. 8

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Oct 5/29
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Culture & Lab
 (Signed) George Emery M. D.
10/9/29 (Address) 870 Charison Rd

*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 Forest Hill DATE OF BURIAL Oct-12-29
 20. UNDERTAKER Mrs. C. L. Forester ADDRESS W. C. 2nd

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

V. 5, NO. 2

235
31
2

Eaching citizen - Dr. Emery

Dr. [unclear]
[unclear]
[unclear]