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

Do not use this space.

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1. PLACE OF DEATH
County Dunklin — Registration District No. 288
Township — Primary Registration District No. 4172 — File No.
City Kennett (No. , St. , Ward) — Registered No.

2. FULL NAME Ethel McClain

(a) Residence. No. (Usual place of abode) St., Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 17 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 13-1928

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	1	6	25	

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) Duncan
(STATE OR COUNTRY) Miss.

PARENTS

10. NAME OF FATHER E.B. McClain
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Ola Belle McClain
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Malden
(STATE OR COUNTRY) Mo.

14. INFORMANT W.F. Young
(Address) Kennett, Mo.

15. FILED 1/10, 1930 REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/7 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 7, 1930, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 9:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculer meningitis

23A.

24A ... (duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (SECONDARY) Hooping Cough the followed By tuberculosis (duration) 1 yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED,
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Geo. J. Gilmore D. D.
, 19 (Address) Kennett 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
Hazel	Jan 1930
20. UNDERTAKER	ADDRESS
Baldwin Funeral Hm. Co.	Kennett Mo

Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S signature and state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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cated by check marks, lacking from the death certificate:

Name: Ethel McClain

Who died at: Kennett, Mo. on Jan. 7 1930,

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or
town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years ____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Tubercular Meningitis

Contributory: Whooping Cough followed by tubercular Pulmonary

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? _____

Name of physician: George Gilmore DO

Address of physician: Kennett mo

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Dunklin Registration District No. 288 File No.
Township Registered No.
City Kennett (No. St. Ward)

2. FULL NAME Ethel 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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF 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)

PARENTS
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)

14.
INFORMANT
(Address)

15. FILED 1/10 1930 Wheeler Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/7 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration)....yrs. ....mos. ....ds.

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

18. WHERE WAS DISEASE CONTRACTED
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)

*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 Jan 8 1930

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully considered. AGE should be GIVEN EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. ... of OCCUPATION is very ...

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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