MAR 25 1930

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

Do not use this space.

1. PLACE OF DEATH
County Chariton Co
Township Salisbury
City ~~Shannondale~~ No. ..... St. ..... Ward)

Registration District No. 175
Primary Registration District No. 5-243

File No. 4374
Registered No. 8

2. FULL NAME Julia Edeth McClair

(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: Female
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-10-1929

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	3	24	

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) Chariton Co.

PARENTS
10. NAME OF FATHER Paul McClair
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Chariton Co.
12. MAIDEN NAME OF MOTHER Julia Hayes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Chariton Co

14. INFORMANT Paul McClair
(Address) Salisbury Mo

15. FILED 5/4, 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1930, to Feb 4, 1930 that I last saw her alive on Feb 4, 1930, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
107A Primary

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

CONTRIBUTORY (SECONDARY) 100A

(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) William W. Fellows, M. D.
5/4, 1930 (Address) Salisbury, 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: Porters Chapel
DATE OF BURIAL: 2-5 1930

20. UNDERTAKER: Winkelmeyer Bros
ADDRESS: Salisbury

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.