

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

Do not use this space.

24056

1. PLACE OF DEATH

County St. Francois
Township Jeffersville
City Jeffersville (No.)

Registration District No. 771
Primary Registration District No. 6017

File No.
Registered No.
St. Ward)

2. FULL NAME

Alta Ruth McClanahan

(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 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 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) Sept-26-1900.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>29</u>	<u>9</u>	<u>20.</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Francois Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Joseph McClanahan

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

12. MAIDEN NAME OF MOTHER Narah McClanahan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Francois Co Mo
(STATE OR COUNTRY)

14. INFORMANT Sarah Sumpter
(Address) Elvins Rte 1 Mo

15. July 20 19 30 J. W. Gali
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) July 20 19 30.
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 _____ 2 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epilepsy.
ISB

(duration) 8 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Erysipelas.
(duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED ISB
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS Evidence after death.
(Signed) R. B. Keith-Chenier M. D.
July 20, 19 30 (Address) DuBois 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 Hamilton Ave DuBois Mo DATE OF BURIAL 20 7 30

20. UNDERTAKER Geo. ... ADDRESS ...

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 of deceased should be given.

Aug 26 1930

