

NOV 21 1930

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

Do not use this space.

32396

1. PLACE OF DEATH

County

Clay

Registration District No.

198

Township

Tushey River

Primary Registration District No.

3011

City

Evelsior Springs

File No.

Registered No.

105

St.

Ward)

2. FULL NAME

Nita May McClellan

(a) Residence No.

Evelsior Springs, Mo.

Sassaparilla

Livonia Mo.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

19

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)

Single

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

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

Nov 21 - 1910

7. AGE

19.

YEARS

MONTHS

1

DAYS

2

If LESS than 1 day, hrs. or min.

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)

Livonia

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Earl E. McClellan

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Mo.

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Marian Baker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Mo.

(STATE OR COUNTRY)

14.

INFORMANT

Earl E. McClellan

(Address)

Livonia Mo.

15.

FILED

Oct 23, 1930

J. D. Crover

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct 23 1930

17.

I HEREBY CERTIFY, That I attended deceased from

10/4/

1930 to

10/23

1930

that I last saw her alive on Oct. 22nd, 1930, and that death occurred, on the date stated above, at 4 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Parenchymatous Nephritis

120

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Livonia Mo.

DID AN OPERATION PRECEDE DEATH? NO DATE OF

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?

usual urinary tests

(Signed) E. D. Berry, M. D.

10/23, 1930 (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

Livonia Mo.

Oct 24 1930

20. UNDERTAKER

ADDRESS

John C. Prather Ex. Springs

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.

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BATION 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 Clay Registration District No. 198 File No. _____
 Township _____ Primary Registration District No. 3011 Registered No. 105
 City Excelsior Springs (No. _____) St. _____ Ward _____

2. FULL NAME

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

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 12/6 1930 YD. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 1930

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:

Acute Parenchymatous Nephritis
possibly scarlet fever
about a yr ago, but no
diagnosis made at
the time, and no lab kept

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) Henry _____, 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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

N. B.—Every item of information should be carefully checked. A. should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRING REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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