MAY 27 1936

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

16640

1. PLACE OF DEATH. County St Francois Registration District No. 771 File No.
Township Primary Registration District No. 4462 Registered No.
City Bismarck (No. St. Ward)

2. FULL NAME Edward McClary

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 6th 1868

7. AGE: Years 67 | Months 9 | Days 29 | 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) Laborer
(c) Name of employer

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

PARENTS
10. NAME OF FATHER James McClary
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Jane Rodgers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Washington Co Mo

14. INFORMANT Sarrah McClary
(Address) Bismarck Mo.

15. FILED 4/5, 1936 F. W. Gale MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 5 1936

17. I HEREBY CERTIFY, That I attended deceased from 11-2, 1935, to 4-5, 1936, that I last saw h. alive on 4-5, 1936, and that death occurred, on the date stated above, at 1 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Albumin

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Jas W. Hoffman, M. D.
4/5, 1936 (Address) Bismarck,

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Presbyterian Cemetery near Caledonia Mo. | DATE OF BURIAL 4-7 1936

20. UNDERTAKER Caldwell Bros | ADDRESS Flat River Mo.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS