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.

REC'D APR 15 1939

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

10369
Do not use this space.

1. PLACE OF DEATH
(a) County Cape Girardeau — Registration District No. 124
(b) Township — Primary Registration District No. 4070 — Registered No. 10
(c) City Jackson — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred ..... yrs. mos. ds. (f) How long in U. S., if of foreign birth? ..... yrs. mos. ds.

2. PRINT FULL NAME Amos Byrd McLain
(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Lara Stewart McLain
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 10 1865
7. AGE YEARS 73 MONTHS 10 DAYS 16 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oriole, Missouri

FATHER
13. NAME David McLain
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oriole Missouri

MOTHER
15. MAIDEN NAME Katherine McClard
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oriole Missouri

17. INFORMANT (ADDRESS) Russell McLain Cape Gir Mo R R 1
18. BURIAL, CREMATION, OR REMOVAL
PLACE Russell Heights DATE 3/28 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) McCombs Furn. Mud Co Jackson Mo.
20. FILED 3-27 1939 D. G. Sirbro Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26, 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1939 to Mch 26, 1939
I last saw him alive on Mch 26 1936 Death is said to have occurred on the date stated above, at 6 30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Liver	1938

Other contributory causes of importance: 46

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) [signature], M. D.
(Address) Jackson Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.