

REC'D APR 19 1939

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

10703
Do not use this space.

1. PLACE OF DEATH
 (a) County Dunklin 2 Registration District No. 284
 (b) Township Holcomb 1 Primary Registration District No. 5404 B, Registered No. _____
 (c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 James H. McLean
 (a) Residence, No. 245 White Oak St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (writes the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna McLean
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-5-1867
 7. AGE YEARS 63 MONTHS 0 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Farming
 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) Mo.
 FATHER 13. NAME James McLean
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.
 MOTHER 15. MAIDEN NAME Martha Ellis
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.
 17. INFORMANT Wife Anna McLean (ADDRESS) White Oak
 18. BURIAL, CREMATION, OR REMOVAL PLACE Stanfield DATE March 13, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Landerston Campbell Mo.
 20. FILED _____, 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 12, 1939
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ P. M.
 The principal cause of death and related causes of importance were as follows:
Streptococcus Septicemia
 Date of onset _____
 Other contributory causes of importance:
from South extraction
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Leu Was there an autopsy? _____
 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) W. H. Campbell, M. D.
 (Address) 259 Holcomb Mo.

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.

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 comply with the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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10703
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1. PLACE OF DEATH

(a) County Dunklin Registration District No. 286
(b) Township Holcomb Primary Registration District No. 5404 B
(c) City _____ (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. (0) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. _____

2. PRINT FULL NAME

(a) Residence, No. James H. McLean 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 M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-5-1867

7. AGE YEARS 62 MONTHS 0 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. Farming
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) _____

FATHER 13. NAME James McLean

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME Martha Ellis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Anna McLean
White Oak mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Stanfield DATE 3-13 1939

19. FUNERAL DIRECTOR (ADDRESS) Landess & Son
Campbell mo

20. FILED 4-10 1939 J. H. Anderson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-13 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ p. m.
The principal cause of death and related causes of importance were as follows:

Streptococcus infection Date of onset _____

Other contributory causes of importance: from tooth extraction

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 J. H. Cochran M. D.
(Signed) _____

(Address) Holcomb, mo.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

