

OCT 10 1939

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

33379
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Clair 3 Registration District No. 765
 (b) Township Osceola 1 Primary Registration District No. 4460 Registered No. 15
 (c) City Osceola (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 John Francis McClain
 (a) Residence, No. _____ St. _____ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Bessie Guy
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 14-1871
 7. AGE YEARS 68 MONTHS 9 DAYS 21 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clergyman
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 5, 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 _____ m.
 The principal cause of death and related causes of importance were as follows:
Dropped dead on street due to chronic heart disease
 Date of onset _____
 Other contributory causes of importance: 45 to 50
 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? Yes
 If so, specify _____
 (Signed) Osceola _____ M. D.
 (Address) Osceola Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 FATHER 13. NAME Unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT Mrs. Bessie McClain
 (ADDRESS) Osceola
 18. BURIAL, CREMATION, OR REMOVAL PLACE Wrights Creek DATE July 6, 1939
 19. FUNERAL DIRECTOR (NAME) Osceola Mo
 (ADDRESS) _____
 20. FILED Aug 1, 1939 Ruth Seavers
 Local Registrar.

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.

RECEIVED

District Health Officer No. 7,

District File Number A-39-1345

Date Filed 9-19-39

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. 2097

P. O. Address Oscola

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.

