

DEC 13 1939

Registration District No. **498**

Primary Registration District No. **3211**

Registrar's No. **152**

1. PLACE OF DEATH:
(a) County Salas
(b) City or town Excelsior Springs Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCleary Sanitarium 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 days (Specify whether)
years, months or days 1111

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Washington
(c) City or town MORROWVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME JAMES MCLAREN
(b) If veteran, name war no (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 18th
year 1939 hour 3 minute 10 A. M.

4. Sex Male 5. Color or race White
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If
alive _____ years
7. Birth date of deceased Sept unknown 18 60
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Nov - 6 - 1939 to Nov - 18 - 1939
that I last saw him alive on Nov 18 - 1939
and that death occurred on the date and hour stated above.

8. AGE: Years 79 Months ✓ Days ✓ If less than one day
hr. ✓ min. ✓

Immediate cause of death
Bronchial pneumonia rth
Due to Valvular heart disease
& Arteriosclerosis
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Frondalic Wis
(City, town, or county) (State or foreign country)
10. Usual occupation Retired farmer
11. Industry or business _____
12. Name James M. McLaren
13. Birthplace Scotland
(City, town, or county) (State or foreign country)
14. Maiden name Mrs. Margaret McLaren
15. Birthplace Scotland
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Alex E. Mac Gupor
(b) Address 4738 Oak R C Mt.
17. (a) Removal (b) Date thereof 11/19/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Morrowville Mo
18. (a) Signature of funeral director W. H. H. H. H.
(b) Address Excelsior Springs
19. (a) Nov 18, 1939 (b) W. H. H. H. H.
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury _____
23. Signature E. B. Keeler (M. D. or other) _____
Address McCleary Sanitarium Date signed 11/18/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

FORM 1 1938

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 12/6/39

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 _____

Scott W. Hochensmith, Registered Apprentice No. _____
working under my personal supervision.

Signed: Scott W. Hochensmith
Licensed Embalmer No. 3596
P. O. Address Excelsior Springs

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.