

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

40580
Do not use this space.

1. PLACE OF DEATH

(a) County Pulaski Registration District No. 714
 (b) Township Big Piney Primary Registration District No. 5947
 (c) City Big Piney (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. da. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 214 Robert J. McClure St.
Big Piney, Mo
 (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 Yvonne McClure

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 26 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 1 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. farm
 10. Date deceased last worked at this occupation (month and year) at work 12-27
 11. Total time (years) spent in this occupation 42 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo

FATHER 13. NAME Robert J. McClure

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

MOTHER 15. MAIDEN NAME Donanda Brown

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

17. INFORMANT (ADDRESS) Mabel Watts

18. BURIAL, CREMATION, OR REMOVAL PLACE Big Piney DATE Nov. 6 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Reed

20. FILED 11-18-1939 S. L. Koonce
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 5 1939

22. I HEREBY CERTIFY That I attended deceased from March 15 1935 to Nov 5 1939
 I last saw him alive on Apr. 24 1935 Death is said to have occurred on the date stated above, at 8 P m.
 The principal cause of death and related causes of importance were as follows:

Paralyzing of left side of body.
 Date of onset

Other contributory causes of importance:
Heart disease & Lung disease

Name of operation Surgical Date of 5-11-39
 What test confirmed diagnosis? Surgical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Yes Date of injury 11-5-39
 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) C. A. Talbot M. D.
 (Address) Wagonville

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.

95622

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number. 1039-454

Licensed Embalmer No.....

Date Filed 12.8.39

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.

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Do not use this space.

PLACE OF DEATH *Pulaski*

(a) County *Pulaski* Registration District No. *714*

(b) Township *Big Piney* Primary Registration District No. *3943*

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

2. PRINT FULL NAME *Robert J. McClure*

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*writes the word*) *m*

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.
53 1 9

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. _____

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 _____

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

MOTHER 15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____, 19 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 5 - 1939*

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

I last saw him _____ 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:
Paralysis of left side of body
Heart lesion
High Blood Pressure

Other contributory causes of importance:
Heart lesion
High Blood Pressure

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 _____
(Signed) *C. A. Talbot*, M. D.
(Address) _____

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

