

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

2371
 Do not use this space.

FILED FEB 13 1940

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 318
 (b) Township SPRINGFIELD Primary Registration District No. 2001
 (c) City SPRINGFIELD (d) Street No. 852 S. Missouri Registered No. 34
 (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 Warren Mc Lain
 (a) Residence, No. 852 S. Missouri 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 (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Arminda Mc Lain (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 3, 1869

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>70</u>	<u>8</u>	<u>7</u>		

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

FATHER 13. NAME unk.
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk.

MOTHER 15. MAIDEN NAME unk.
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk.

17. INFORMANT (ADDRESS) Mrs. Arminda Mc Lain Springfield, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park DATE 1-14-40
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin Johnson Springfield, Mo.
 20. FILED 1/15 1940 Chas. B. George Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-10-40

22. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1939 to Jan 10, 1940
 I last saw him alive on 1-10-40, 1940 Death is said to have occurred on the date stated above, at 10:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Acute Myocarditis following Date of onset
Lobar Pneumonia type II
4 weeks before

Other contributory causes of importance:
Semity

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) A. M. White M. D.
 (Address) Springfield, 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.

JUL 6 1944

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.....

Harlow Knab

Licensed Embalmer No.....

4065

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.

X