

Registration District No. 8

Primary Registration District No. 203

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Benton
(b) City or town Warsaw
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Benton
(c) City or town Warsaw (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME Larry Leon McClood

3. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

4. Sex male 5. Color or race wh 6. (a) Single, widowed, married, divorced ✓

8. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 10 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 3 3 hr. min.

9. Birthplace Warsaw MO
(City, town, or county) (State or foreign country)

10. Usual occupation halibut

11. Industry or business _____

12. Name Lawrence Harvey McClood

13. Birthplace Warsaw Mo
(City, town, or county) (State or foreign country)

14. Maiden name Marjorie

15. Birthplace Christian, Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant May Porter

(b) Address Warsaw

17. (a) burial (b) Date thereof Jan 14 '41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riverside

18. (a) Signature of funeral director White + Rees

(b) Address WARSAW, MO

19. (a) 1-20-41 (b) Joe A. Logan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13
year 1941 hour 7 minute 00 P. M.

21. I hereby certify that I attended the deceased from Jan 10
1941, to Jan 13, 1941.
that I last saw in alive on Jan 12, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death
Bronchial Pneumonia 4 day
Due to Aspiration 4 wks

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy none

Duration
4 day
4 wks
PHYSICIAN
Underline the cause to which death should be charged statistically.

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? _____

23. Signature Everally (M. D. or other) MD
Address Warsaw, Mo Date signed 1/14/41

8000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 2-41-241

Date Filed 2-6-41

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.