

No. 2  
4-13-40  
4-17-39  
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FILED MAY 13 1941

15290

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 605

Primary Registration District No. 4359

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County New Madrid

(b) City or town Paris, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 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 \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Paris  
(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.? 0 years.

3. (a) PRINT FULL NAME Clarence Junior McKay

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 5  
year 1941 hour 7:00 minute 0 M.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced 50

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 12 1937  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr. 3 1941, to Apr 5 1941; that I last saw him alive on April 3 1941; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>4</u>	<u>1</u>	<u>23</u>	hr. _____ min. _____

Immediate cause of death Bronchial pneumonia

Due to measles

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Dexter Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation mil

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Clarence McKay

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

14. Maiden name Mary Frelts

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

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? \_\_\_\_\_

16. (a) Informant Clarence McKay

(b) Address Paris

17. (a) Burial (b) Date thereof 4-6-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden

18. (a) Signature of funeral director 534

(b) Address \_\_\_\_\_

19. (a) 4-5-41 (b) Dr. Carl Gustaf  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature Dr. Carl Gustaf (M. D. or other) \_\_\_\_\_

Address Paris Date signed Mo

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

**RECEIVED**

District Health Officer No. 2,

District File Number 54-051

Date Filed 5/8/41

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**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, fact should be so stated above.**