

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1205

FILED JUN 13 1942

Registration District No. 179

Primary Registration District No. 5691

Registrar's No. 13

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Cypress Sup. Dist
(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 _____
(Specify whether years, months or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County McDonald
(c) City or town Rural Stella St #2
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Guy Scott McClelland

3. (b) If veteran, name war. ✓

3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 5. (a) Single, widowed, married, divorced. Married
6. (b) Name of husband or wife Earl Ann McClelland 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased Feb. 8 - 1886
(Month) (Day) (Year)

8. AGE: Years 56 Months 3 Days 8 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name William McClelland

13. Birthplace Unknown Ireland (City, town, or county) (State or foreign country)

14. Maiden name Ide A. Judd

15. Birthplace Unknown W. Vir. (City, town, or county) (State or foreign country)

16. (a) Informant Miss McClelland

(b) Address Stella St #2

17. (a) Burial (b) Date thereof 4-19-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cypress Cemetery

18. (a) Signature of funeral director Chas. Williams

(b) Address Sumner, Mo.

19. (a) 5-15-42 (b) Wm. Martin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16
year 1942 hour 3:00 minute 50 P.M.

21. I hereby certify that I attended the deceased from NO Physician 19____;
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Stroke Duration _____
Cerebral Hemorrhage

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature S. B. Knox (M. D. or other) _____
Address Sumner, Mo. Date April 16-42

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

RECEIVED

District Health Officer No. 6,

District File Number 642-840

Date Filed JUN 11 1942

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.