S. No. 2
I—9-4-41
5-17-39
X29484

2628

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 163 Primary Registration District No. 3036 Registrar's No. 6

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

1. PLACE OF DEATH:
(a) County: Jefferson
(b) City or town: DeSoto
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 612 N. Fifth. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: None (Specify whether years, months or days)
In this community: 15 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mis souri (b) County: Jefferson
(c) City or town: DeSoto
(If outside city or town limits, write "RURAL")
(d) Street No.: 612 N. Fifth
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: JAMES ROY McCLELLAND
3. (b) If veteran, name war: No
3. (c) Social Security No. 702-16-0231
4. Sex: male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mary Lou Fatchett
6. (c) Age of husband or wife if alive: 58 years
7. Birth date of deceased: April (Month) 8 (Day) 1879 (Year)

8. AGE: Years 63 Months 9 Days 13 If less than one day ... hr. ... min.

9. Birthplace: Hills View (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Section Foreman.
11. Industry or business: Mo. Pac.
FATHER
12. Name: Chrles McClelland
13. Birthplace: ? (City, town, or county) ? (State or foreign country)
MOTHER
14. Maiden name: Mary Watt
15. Birthplace: ? (City, town, or county) ? (State or foreign country)
16. (a) Informant: Mrs Harvey Schneider
(b) Address: 1205 N 2nd DeSoto Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 24 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: DeSoto. (Woodlawn)
18. (a) Signature of funeral director: Lee Mothershead
(b) Address: DeSoto, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 21 year 1943 hour 10 minute 20 A.M.
21. I hereby certify that I attended the deceased from Jan 14-43, 19..., to Jan 21, 1943
that I last saw him alive on Jan 20, 1943
and that death occurred on the date and hour stated above.
Acute Edema of L. Ventricle
Immediate cause of death: Edema of Lungs — Duration: 14da
Due to: Severe Influenza Pneumonia Lower Lobes R & Left Lungs — 20da
Due to:
Other conditions: Mitral Stenosis — 5yrs.
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy: 108

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: J. A. Elders (M. D. or other) MD
Address: DeSoto Mo Date signed 1-23-43

387

(Licensed Embalmer's Statement on Reverse Side)

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 Joe Motherwhead

Licensed Embalmer No. 3531

P. O. Address DeSoto mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2628

Registration District No. 163 Primary Registration District No. 3031 Registrar's No. 6

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town De Soto
(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
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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 James Roy McClelland

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April 8 1899
(Month) (Day) (Year)

8. AGE: Years 63 Months 9 Days 13 If less than one day min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 1-26-43 (Date received local registrar) (b) Fern Spencer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death acute dilation of L.D. entrical and Edema of lungs

Due to Severe Influenza Pneumonia Fourth lobes

Due to R & left lungs.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY