S. No. 2
M—5-42
5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 25 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5320

State File No. .....

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 529

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital No. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-30-43-1-31-43 (Specify whether

In this community 15 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 8

(d) Street No. 1225 Highland (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ROBERT MCCLAIN

3. (b) If veteran, name war no.

3. (c) Social Security No. None

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased August (Month) 10 (Day) 1863 (Year)

8. AGE:

Years	Months	Days	If less than one day
79	5	21	hr. min.

9. Birthplace Rayford County (City, town, or county) Tennessee (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

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

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director E. Sterling Bill

(b) Address 1212 Vine St.

19. (a) 2-2-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month January day 31 year 1943 hour 12:30 minute p. M.

21. I hereby certify that I attended the deceased from January 30, 1943, to January 31, 1943; that I last saw him alive on January 31, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Due to Hydronephrosis 12 Yr	
Due to Hypertrophy of the Prostate	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Same as above

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 G C Dunn (M. D. ~~or other~~)

Address Gen. Hosp. #2-600 E 22 Date signed 2-2-43

361

(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 E. Sterling Bills

Licensed Embalmer No.....

P. O. Address 1212 Vine St. K.C.

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.