

FILED JUN 24 1943

Registration District No. 779

Primary Registration District No. 1002

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:  
2 E. 54th St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 years  
(Specify whether years, months or days)

In this community 17 years

3. (a) PRINT FULL NAME Baxter D. McClain

3. (b) If veteran, name war Spanish American & World War

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Katherine A. McClain

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased December 9 1871  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>5</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Attorney

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

MOTHER FATHER { 12. Name Noah H. McClain

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

14. Maiden name Elizabeth Evans

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

16. (a) Informant Mrs. Katherine A. McClain

(b) Address 2 East 54th St.

17. (a) Cremation (b) Date thereof 6-4-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Fresman Mortuary

(b) Address Kansas City, Mo.

19. (a) 6-3-43 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2 E. 54th St.  
(If rural, give location)

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

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2  
year 1943 hour 11 minute 40 AM.

21. I hereby certify that I attended the deceased from 6-2 to 6-2 1943  
that I last saw him alive on 6-2 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Crown artery sclerosis

Due to Chronic Myocarditis

Due to 93.11

Other conditions Sanctions  
(Include pregnancy within 3 months of death)

PHYSICIAN

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

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

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) no

(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 Frank J. [unclear] M. D. or other \_\_\_\_\_  
Address 316 [unclear] Rd. Date signed 6-2-43

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JUL 8 - 1943

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 Clarence W. Chiles

Licensed Embalmer No. 3473

P. O. Address 76 e No.

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.

*315  
W. of  
Chiles*