

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. **2615**

FD 111N 24 1943
 Registration District No. **149**

Primary Registration District No. **1002**

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:
Research Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **24 Hours**
(Specify whether)
 In this community **7 Months**
years, months or days

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. **2122 East 47 St Terrace**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Eva C McClary**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Delbert F. McClary**
 6. (c) Age of husband or wife if alive **62** years
 7. Birth date of deceased **Dec 7 1897**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	45	6	2	hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Marion Hankins**
 13. Birthplace **Iowa**
(City, town, or county) (State or foreign country)
 14. Maiden name **Ora Hill**
 15. Birthplace **Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Delbert F. McClary**
 (b) Address **2122 East 47 St Terrace**

17. (a) **Burial** (b) Date thereof **June 12-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **J. Wagner**
 (b) Address **Kansas City Mo.**

19. (a) **6-9-43** (b) **P. B. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **June** day **9th**
 year **1943** hour **12** minute **01** P. M.

21. I hereby certify that I attended the deceased from **5/14/43**
but notes 3 years to 20 days before 1943
 that I last saw her alive on **June 9**, 19**43**
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Acute Cardiac Decomposition
General anasarca by nephrosis
 Due to **Dilated Heart - Hypertension**
Myocarditis
 Duration **3 to 4 weeks**
6 years

Other conditions:
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____

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 **Lindsay S. McNeil** (M. D. or other) _____
 Address **132 Professional Bldg** Date signed **June 9, 43**

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

*In testimony & witness
Prof. Bedy.*

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 *Cecil R. Walker*.....

Licensed Embalmer No. *3807*.....

P. O. Address. *H. C. Mo*.....

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.