

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

X3287

FILED SEP 8 1943 275

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Rolla
(b) City or town Rolla
(c) Name of hospital or institution:
McFarland Memorial
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Rolla
(c) City or town Rolla
(d) Street No.....
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Clifford Allen Gearitt Jr.

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race wh 6. (a) Single, widowed, married, divorced div

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

7. Birth date of deceased July 11 1943
(Month) (Day) (Year)

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

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

10. Usual occupation lab

11. Industry of business.....

12. Name Clifford Allen Gearitt

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

14. Maiden name Phyllis E. Tucker

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

16. (a) Informant Clifford A. Gearitt
(b) Address Rolla Mo

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

(c) Place: burial or cremation Rolla Cem.
18. (a) Signature of funeral director W. E. Brown
(b) Address Rolla Mo
19. (a) Aug 8 1943 (b) Rolla Mo
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 5
year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from Aug 4
1943 to Aug 5 1943
that I last saw h. in alive on Aug 5 1943
and that death occurred on the date and hour stated above.

Immediate cause of death allergic colitis
Duration 24 hrs

Due to unknown substance

Due to.....

Other conditions (Include pregnancy within 3 months of death) 1190

Major findings: Of operations.....

Of autopsy.....

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 C

Signature M. D. Underwood (M. D. or other) M. D.
Address Rolla, Mo Date signed 8/8/43

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..... *S. L. Y. Jones*.....
Licensed Embalmer No. *3394*.....
P. O. Address..... *Roller 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.