. No. 2
M—2-43
5-17-39

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33864

FILED NOV 1 1943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4250

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: K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 16 days (Specify whether years, months or days)
In this community: unknown

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.: 526½ E 12th
(If rural, give location)
(e) Citizen of foreign country? (Yes or No): No
If yes, name country:

48
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3. (a) PRINT FULL NAME: William F. McClanahan

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

3. (c) Social Security No.: none

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife:

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

7. Birth date of deceased: Dec (Month) 10 (Day) 1866 (Year)

8. AGE: Years 76 Months 9 Days 17 If less than one day hr. min.

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

10. Usual occupation: none

11. Industry or business:

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

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

16. (a) Informant: Record Clerk
(b) Address: K C Gen Hospt

17. (a) Burial: (Burial, cremation, or removal) (b) Date thereof: Oct-6-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Maple Hill MC Home

18. (a) Signature of funeral director: Wm A Johnson
(b) Address: City Mortician

19. (a) 10-6-43 (Date received local registrar) (b) J. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th year 1943 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 11th 1943 to Sept. 27th 1943 that I last saw him alive on Sept. 27th 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Metastatic Carcinoma	
Due to: Bronchogenic Carcinoma	
Due to: 47c	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: See 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: Emery R. Thomas (M. D. or other)
Address: Med. Dir. Gen'l Hosp. Date signed 9-28-43

(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.....

Licensed Embalmer No.....

P. O. Address.....

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.