

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38335**

Registrar's No. **257**

NOV 18 1943
Registration District No. **146**

Primary Registration District No. **3026**

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution:
Independence Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 week**
(Specify whether)

In this community **30 years**
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. **6040 Walrond**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **Mela Tina Mc Cann**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Fe** 5. Color or race **Wh**

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

6. (b) Name of husband or wife **James Mc Cann**

6. (c) Age of husband or wife if alive **59** years

7. Birth date of deceased **June 15th, 1872**
(Month) (Day) (Year)

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

71 **3** **26** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **James W. Claycomb**

{ 13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **Elizabeth Summers**

{ 15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **James Mc Cann**

(b) Address **6040 Walrond**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10/13/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt Washington**

18. (a) Signature of funeral director **Earp Funeral Home**

(b) Address **4139 East 15th, St**

19. (a) **10-12-43** (Date received local registrar)

J. J. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **11th,**
year **1943** hour **6** minute **45** A. M.

21. I hereby certify that I attended the deceased from **10-10**
19 **10-11** 19 **43**
that I last saw **or** alive on **10/10/43** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death

Bronchial Pneumonia 3 days

Partial 2 months

Carcinoma Stomach 2 yrs

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

Major findings:
Of operations **48F**

Of autopsy

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?

While at work (Specify type of place) Means of injury

23. Signature **[Signature]** (M. D. or other)

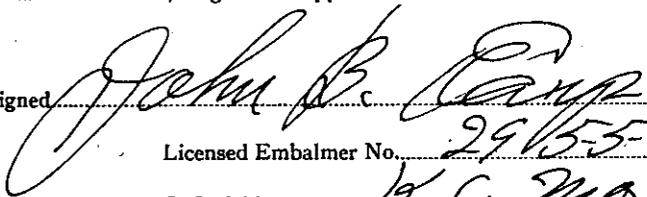
Address **[Signature]** Date signed **10-11-43**

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

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. 29155
P. O. Address W. 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.