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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 10 1944

Registration District No. 316

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6074

State File No. 8167

Registrar's No. 34

1. PLACE OF DEATH:
(a) County ST FRANCOIS
(b) City or town RURAL RANDOLPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: / Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 70 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 94
(a) State MO (b) County ST FRANCOIS
(c) City or town RURAL 0
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR MITCHELL MO. 0
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MADISON McCLAIN

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife

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

7. Birth date of deceased NOV. (Month) 11 (Day) 1856 (Year)

8. AGE: Years 87 Months 3 Days 13 If less than one day hr. min.

9. Birthplace MO. (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation Retired

11. Industry or business none

FATHER
12. Name CHARLEY McCLAIN
13. Birthplace MO 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name UNKOWEN
15. Birthplace UNKOWEN 9 (City, town, or county) (State or foreign country)

16. (a) Informant AUTHER McCLAIN
(b) Address LEADWOOD MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (Month) (Day) (Year)
(c) Place: burial or cremation MITCHELL MO

18. (a) Signature of funeral director J. S. Boyer Sr.
(b) Address Leadwood Mo.

19. (a) Feb 29-1944 (Date received local registrar) (b) Byrdie Burmester (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25 year 1944 hour 10 A. M.

21. I hereby certify that I attended the deceased from By Coroner Investigation 19 to Feb 25 1944 that I last saw h. alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

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? (Specify type of place) 9
While at work? (e) Means of injury

23. Signature Clarence Claywell Coroner (M.D. or other)
Address Bonne Terre Mo Date signed 2/25/44

1196

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 344-348

Date Filed 3-7-44

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 Was not Embalmed, Registered Apprentice No. working under my personal supervision.

Signed D. L. Boyce

Licensed Embalmer No. 3445

P. O. Address Leadwood Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.