V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 8 1944

Registration District No. 380

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3076

State File No. 25974

Registrar's No. 89

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

1. PLACE OF DEATH:
(a) County: Vernon
(b) City or town: Nevada Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Nevada City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: about 1/2 hr. (Specify whether years, months or days)
In this community: 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Vernon
(c) City or town: Mile 107
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: no.

3. (a) PRINT FULL NAME: Gary T. McClellan
3. (b) If veteran, name war: no.
3. (c) Social Security No.: no.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: infant
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: April (Month) 6 (Day) 1944 (Year)
8. AGE: Years | Months: 3 | Days: 15 | If less than one day: hr. min.
9. Birthplace: Sheldon, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Earl McClellan
FATHER 13. Birthplace: Mile Mo. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Allie Caton
MOTHER 15. Birthplace: Mo. (City, town, or county) (State or foreign country)
16. (a) Informant: H. O. Lewis
(b) Address: Mile Mo
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: July 22 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Sheldon Cemetery
18. (a) Signature of funeral director: G. B. Berry Sons
(b) Address: Sheldon Mo.
19. (a) 7-25-44 (Date received local registrar) (b) Hazel B. Beirck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1944 hour 09 minute 10 A.M.
21. I hereby certify that I attended the deceased from July 18 1944 to July 21 1944 that I last saw him alive on July 21 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Gastro Enteritis	5 days
Due to: Dont Know	
Due to:	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations: none
Of autopsy: none

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: W. Love M.D. (M. D. or other)
Address: Nevada, Mo Date signed July 21/44

1331 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 7-44-889
Date Filed 8-4-44

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 ....., Registered Apprentice No. ....., working under my personal supervision.

Signed Carroll T. Beeny

Licensed Embalmer No. 2385

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.