

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 321

Registration District No. 42 Primary Registration District No. 100

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution: State Hospital No 2  
(d) Length of stay: In hospital or institution 7 days  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Dickall  
(c) City or town Osborn  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lincoln McCLURE

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar day 19  
year 1940 hour 8-40 minute 0 M.

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

21. I hereby certify that I attended the deceased from 3-18 1940 to 3-19 1940  
that I last saw him alive on 3-19 1940  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lara McClure 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 16 1864  
(Month) (Day) (Year)

Immediate cause of death Hypostatic Pneumonia & Rheumatoid  
Duration \_\_\_\_\_

8. AGE: Years 80 Months 7 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Red meldon - general debility

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

Due to \_\_\_\_\_  
Other conditions Swine Flu Infection  
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer

Major findings: Of operations \_\_\_\_\_  
Of autopsy 109  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name Elisha McClure  
13. Birthplace not given 9  
(City, town, or county) (State or foreign country)  
14. Maiden name not given  
15. Birthplace not given 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Hospital  
(b) Address St Joseph Mo

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof Mar 22 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Home Well Country

(c) Where did injury occur? \_\_\_\_\_ (City or town) (Country) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director St Joseph Mo  
(b) Address \_\_\_\_\_  
19. (a) 3-22-45 (b) Richard J. Tickle  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature BS Salyer (M. D. or other) 3/19/40  
Address 85 20th St Mo Date signed \_\_\_\_\_

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

MOTHER FATHER

1397

**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

*F. G. Lyons*

Licensed Embalmer No.

*952*

P. O. Address

*Stewartville 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.**