

State File No.

FILED OCT 23 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4140

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

48
3
8

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: COLONIAL REST HOME - 761 NORNALL RD
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 YEAR
 (Specify whether years, months or days) 8 YEARS

3. (a) PRINT FULL NAME JOHN W McCLELLAND
 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 WIDOWED
 6. (b) Name of husband or wife MRS MARGARET A. McCLELLAND
 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased NOVEMBER 28 1953
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 10 9 hr. min.

9. Birthplace Sisbon Iowa
 (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name James Mc Clelland
 13. Birthplace Scotland
 (City, town, or county) (State or foreign country)
 14. Maiden name Margaret Stone
 15. Birthplace Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant Dr. J. C. McClelland

(b) Address 627 East 70th Terrace

17. (a) Cremation (b) Date thereof Oct. 8, 1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEW COMERS SQS

18. (a) Signature of funeral director D. W. Newcomers

(b) Address 1401 Brush Creek Blvd.

19. (a) 10-8-45 (b) Geraldine Holmes
 (Date received local registrar) (Registrar's signature)

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. 627 EAST 70th TERRACE
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 7
 year 1945 hour 1 minute 29 P. M.
 21. I hereby certify that I attended the deceased from III/17/42
 to 8/17/45, 1945
 that I last saw him alive on 8/17/45, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Hardening of arteries
 Due to
 Due to
 Other conditions: 97
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations
 Of autopsy

Duration
 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 DR. W. W. ... (M.D. or other)
 Address 424 ... Date signed 8/18/45

104.0.1
4/26/24
11/24
P. O. Address: KCMO
KAS 493

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.....

Emile M. Colburn

Licensed Embalmer No..... *3506*

P. O. Address..... *KCMO*

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.