

FILED APR 30 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 3008

1. PLACE OF DEATH

(a) County Callaway  
Fulton  
(b) City or town  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
State Hospital No 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway  
(c) City or town Fulton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1012 N. Bluff St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN SANFORD McCLELLIAN

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Stella Gilmore McC 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased April 24 1877  
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 15 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Attendant at State Hospital

11. Industry or business \_\_\_\_\_

12. Name Thomas Oliver McClellan

13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Stella McClellan

(b) Address Fulton, Missouri

17. (a) Burial (b) Date thereof 4-11-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation White Cloud Cemetary

18. (a) Signature of funeral director Hallice Funeral Home

(b) Address 7th & St. Fulton, Mo.

19. (a) 4-11-1946 (b) Jane Mosek Hoff  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day April  
year 1946 hour 8 minute 50 A.M.

21. I hereby certify that I attended the deceased from March 28, 1946, to April 9, 1946,  
that I last saw him alive on April 8, 1946,  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis, Chronic

Due to Generalized Hypertension

Due to Generalized Arteriosclerosis

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.  
932

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 George J. Wood (M. D. or other) \_\_\_\_\_

Address Fulton Date signed 4/11/46

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

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 4-29-46

---

---

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 Peniel C. Browning  
Licensed Embalmer No. 2724  
P. O. Address Fulton 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.