

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29735
Registrar's No. 296

FILED SEP 16 1946

Registration District No. 47 Primary Registration District No. 5757

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

1. PLACE OF DEATH:

(a) County CALLAWAY

(b) City or town RURAL Auxvasse
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
R.F.D. PORTLAND, MO 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 _____ years, months or days

3. (a) PRINT FULL NAME MARION DAVIS McCLELLAN

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 Lonie McClellan 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased JULY 15 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74 1 16 _____ hr. _____ min.

9. Birthplace PORTLAND MO 1
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

MOTHER FATHER

11. Industry or business _____

12. Name JAMES McCLELLAN

13. Birthplace OK. _____

14. Maiden name MARTHA HinVILL

15. Birthplace BOWLING GREEN MO 0
(City, town, or county) (State or foreign country)

16. (a) Informant MRS MARION McCLELLAN

(b) Address PORTLAND, MO

17. (a) BURIAL (b) Date thereof SEPT. 5, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riderview STEEDMAN

18. (a) Signature of funeral director Glen Y. Maupin

(b) Address 712 Camp St. Fulton MO

19. (a) 9-5-1946 (b) Jouis M. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALLAWAY 14

(c) City or town RURAL _____
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. PORTLAND, MO _____
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year _____ hour 11 minute 25

21. I hereby certify that I attended the deceased from 4-20
_____ 1946 to 9-1 1946
8-26

that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction
hypertensive + chronic
nephritis, parenchymatous

Due to _____

Due to _____

Other conditions Postobstructive Hypertrophy
+ Cyanosis

Major findings: Of operations _____

Of autopsy 1318

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? _____

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

23. Signature W. O. Boyne (M. D. or other) _____
Address W. O. Boyne Date signed 9/3/46

~~97-5-6~~
~~67-97-5~~
RECEIVED
District Health Officer No. 91

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..... *Glen Y. Maypin*
Licensed Embalmer No..... *19725*
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.