

**FILED OCT 7 1946 STANDARD CERTIFICATE OF DEATH**

Registration District No. 252

Primary Registration District No. 4382

Registrar's No. 14

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

**1. PLACE OF DEATH:**

(a) County Nodaway  
 (b) City or town Parnell  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 3  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether  
 In this community 1 week  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Iowa (b) County 911  
 (c) City or town Richland  
(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.....

3. (a) PRINT FULL NAME Cecil Leon McClure

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Walter McClure 6. (c) Age of husband or wife if alive..... years  
 7. Birth date of deceased December 19 1900  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
45 8 29 hr. min.

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

10. Usual occupation house wife

11. Industry or business.....  
 12. Name Benjamin Waters  
 13. Birthplace unknown Iowa  
(City, town, or county) (State or foreign country)  
 14. Maiden name May Ward  
 15. Birthplace unknown Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter McClure  
 (b) Address Richland, Iowa

17. (a) Removal (b) Date thereof 9-19-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director W. H. Hoffert  
 (b) Address Albany, Mo

19. (a) 9-24-46 (b) W. H. Hoffert  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 9 day 18  
 year 1946 hour 8:00 minute P. M.  
 21. I hereby certify that I attended the deceased from 9-17  
1946, to 9-18, 1946  
 that I last saw her alive on 9-17, 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to.....  
 Due to.....  
 Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: 9411  
 Of operations.....  
 Of autopsy.....

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?..... (2) Means of injury.....

23. Signature Dr. P. J. Sartorius D. or other) P.O.  
 Address Maryville, Mo Date signed 9-18-46

Duration  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

**DISTRICT HEALTH OFFICE**  
**Cameron, Mo.**

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**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 me

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

Signed Clifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany 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.**