

33048

State File No. \_\_\_\_\_

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 138

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution:  
McCleary Clinic  
(If not in hospital or institution, write street number or location)

(d) Length of stay: about 25 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Aretas See McCleary

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male ( ) 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Anna Mary Nelson

6. (c) Age of husband or wife if alive deceased

7. Birth date of deceased August 1 1864  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>2</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace Montgomery County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor of Medicine

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

MOTHER FATHER { 12. Name Thomas A. McCleary

13. Birthplace Sisterville Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Neff

15. Birthplace Pike County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Henry Duderstadt

(b) Address Excelsior Springs, Missouri

17. (a) Removal Removal (b) Date thereof 10-23-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Missouri

18. (a) Signature of funeral director Claude Prichard

(b) Address Excelsior Springs, Missouri

19. (a) 10-22-46 (b) Caroline Butcher  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24

(c) City or town Excelsior Springs 1  
(If outside city or town limits, write "RURAL.")

(d) Street No. \_\_\_\_\_ 1  
(If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21  
 year 1946 hour 1 minute 35 P. M.

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

Immediate cause of death Cerebral Embolism 9/46

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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.

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) (Means of injury)

23. Signature [Signature] (M. D. or R. D.) [Signature]  
 Address Excelsior Springs, Missouri signed 10/27/46

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

31876

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 11-2-46

NOV 20 1946

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Springs, 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.