

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

17515

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED MAY 20 1947

2023

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

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:  
Kansas City General Hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Mo.  
(Specify whether \_\_\_\_\_)  
In this community 2 Years  
years, months or days)

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. 1513 Topping  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME McCluhan, Orville  
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, Married  
6. (b) Name of husband or wife Hattie Mc Cluhan  
6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased July 17 1888  
(Month) (Day) (Year)

8. AGE: Years 58 Months 8 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation night watchman

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

12. Name W. R. McCluhan

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

14. Maiden name Sallie Heisel

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

16. (a) Informant Hattie McCluhan

(b) Address 1513 Topping

17. (a) Removal (b) Date thereof May 6 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carrollton Mo.

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address 918 Brooklyn

19. (a) 5-6-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5  
year 1947 hour 9 minute 55 P.M.  
21. I hereby certify that I attended the deceased from April 4  
to May 5 1947  
that I last saw him alive on May 5 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Massive atelectasis left lung Generalized syphillis

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 308  
Of operations \_\_\_\_\_  
Of autopsy None

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? 0  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Wm W Hart (M. D. or other) MD  
Address Med. Dir. Gen. Hosp. #1 Date signed 5-6-47

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

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

MOTHER FATHER

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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.....

Jerry A. Minor....., Registered Apprentice No. 437  
working under my personal supervision.

Signed Dean Owens.....

Licensed Embalmer No. 4280.....

P. O. Address 918 Broadway  
R. C. 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.**