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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 11 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 924

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:
State Hospital #2 I
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 23 days
(Specify whether)

In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 304 E. Hyde Park
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME. Alexander J. McLaren

3. (b) If veteran, name war None

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 Anna McLaren

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased December 25 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>7</u>	<u>9</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Alexander McLaren

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

14. Maiden name Margaret Mathison

15. Birthplace Unknown Scotland
(City, town, or county) (State or foreign country)

16. (a) Informant Records, State Hosp #2

(b) Address St. Joseph, Mo.

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

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Heurhoffer-Flamm

(b) Address 1946 Colburn St., St. Joseph, Mo.

19. (a) 8-7-47 (b) W. L. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4
year 1947 hour 10 minute 35 P.M.

21. I hereby certify that I attended the deceased from July 12, 1947, to August 4, 1947.
that I last saw him alive on August 4, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death meningitis, acute Duration 19 days

Due to Staphylococcus

Due to _____

Other conditions Senile Psychosis 5 years
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy SIA

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 Delbert P. Johnson (M. D. or other) M.D.

Address State Hosp #2 St Joseph Date signed 8/4/47

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.....

Albert C. Harrington

Licensed Embalmer No..... 3258 Missouri

P. O. Address St. Joseph, 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.