

No. 2
1/47
17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
U.S. DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

31601

FILED SEP 18 1947

State File No.

Registration District No. 156

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Jonlin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution entered Sept 1st
(Specify whether
In this community no record
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Ottawa
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 7 miles East of Miami
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jeff McCleary

(b) If veteran, name war (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 6. (c) Age of husband or wife if alive years
7. Birth date of deceased January 25 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 7 8 hr. min.

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

10. Usual occupation Retired farmer

11. Industry or business

12. Name George McCleary

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

14. Maiden name Nancy Simpson

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

16. (a) Informant Mrs. Jeff McCleary

(b) Address Miami, Oklahoma

17. (a) removal (b) Date thereof Sept. 2, 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation G.A.R. Cem, Miami, Okla

18. (a) Signature of funeral director Cooper Funeral Home

(b) Address Miami, Oklahoma

19. (a) 9-5-47 (b) Blaine Langhin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 2nd
year 1947 hour 6 minute 43 P. M.

21. I hereby certify that I attended the deceased from Sept 1 1947 to 9/2 1947
that I last saw him alive on 9/2 and that death occurred on the date and hour stated above. Duration 7

Immediate cause of death Coronary embolus

Due to Chronic Myocarditis

Due to Gillis Pizzarelle
Other conditions (Include pregnancy within a month of death)

Major findings: Of operations 130
Of autopsy

PHYSICIAN
Underline the cause of 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 (Specify type of place)
While at work Means of injury

23. Signature of Blaine Langhin (M. D. or other) 9/4/47
Address Miami, Okla Date signed 9/4/47

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

MOTHER FATHER

47-8-757

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 Paul A. Harrell
Licensed Embalmer No. 3590
P. O. Address Joplin 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. oet

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jeff McCleary

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

4. Sex m 5. Color or race w 6. (a) Single m widowed, married, divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 68 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or Business

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ of Year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

S-31601