S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34579

FILED NOV 8 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4535

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

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: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hrs. 50 mins. (Specify whether
In this community lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1246 Lawndale 8
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Lee Wayne McClain
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. 12, 1947 (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 5 hr. 50 min.

9. Birthplace Kansas City, Missouri 6
(City, town, or county) (State or foreign country)
10. Usual occupation infant
11. Industry or business
FATHER
12. Name Claude McClain
13. Birthplace Independence, Missouri 0
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Bernice Ione Roberts
15. Birthplace Hillsdale, Kansas 1
(City, town, or county) (State or foreign country)
16. (a) Informant Record Clerk
(b) Address K C Gen Hospt
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-47 (Month) (Day) (Year)
(c) Place: burial or cremation Leeds
18. (a) Signature of funeral director Wm A Schmeyer
(b) Address City mortician
19. (a) 10-29-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1947 hour 7 minute 50 A.M.
21. I hereby certify that I attended the deceased from 9 12 1947 to 9-12 1947
that I last saw him alive on 9-12 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Prematurity	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 159	
Major findings: Of operations	
Of autopsy See above	

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) 0
While at work? (e) Means of injury
23. Signature Wm W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 9-15-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Dr McNamara.

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 not Embalmed, Registered Apprentice No., working under my personal supervision.

Signed Wm. A. Lohmeyer

Licensed Embalmer No. 3089

P. O. Address K 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.