

FILED OCT 29 1947 30  
Registration District No. \_\_\_\_\_

Primary Registration District No. 4484  
Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Fornfelt  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution J  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 days  
years, months or days

3. (a) PRINT FULL NAME Corintha McClard

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

4. Sex F./ 5. Color or race W 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife M.F. McClard 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 1 1869  
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 23 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Bollinger County Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Steven Summers

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

14. Maiden name Cina Ramsey

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

16. (a) Informant Mrs Herman Musbach

(b) Address Fornfelt Mo.

17. (a) Burial (b) Date thereof Oct 25 /47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Russel Heights Cem

18. (a) Signature of funeral director Wilson Statler Seabaugh  
(b) Address Jackson Mo  
(c) Place: burial or cremation \_\_\_\_\_ (Specify type of place)  
(d) Signature \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

19. (a) 10-25-47 (b) E. J. [Signature]  
(Date received local registrar) (Registrar's signature) Address \_\_\_\_\_ Date signed 10-25-47

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1030 Papin St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24 year 1947 hour 8 minute A M.

21. I hereby certify that I attended the deceased from Oct. 15 1947 to Oct. 24 1947 that I last saw her alive on Oct. 22 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis  
Due to Insanity  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations gastro

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

0  
2  
0

RECEIVED

District Health Office No. 2,

District File Number 1047-139

Date Filed 10-28-47

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.