

No. 2
15-43
17-39
X36671

FILED DEC 15 1947

Registration District No. **7**

Primary Registration District No. **3025**

Registrar's No. **47**

1. PLACE OF DEATH:

(a) County **HOWELL**
(b) City or town **WEST PLAINS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
813 WASHINGTON AVE.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **No** (Specify whether **1**)
In this community **15 YEARS** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **HOWELL 46**
(c) City or town **WEST PLAINS**
(If outside city or town limits, write "RURAL")
(d) Street No. **south Suburbs**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **SAMUEL EVERETT McCLANAHAN**

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

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **divorced**
6. (b) Name of husband or wife **3** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **MAY 7, 1893**
(Month) (Day) (Year)

8. AGE: Years **54** Months **6** Days **15** If less than one day **0** hr. **0** min.

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

10. Usual occupation **None**

11. Industry or business **None**

12. Name **Sam. B. McClanahan**

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

14. Maiden name **Permelia Jane Sisco**

15. Birthplace **ALTON, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. W. C. Brewer**

(b) Address **WEST PLAINS, Mo., 813 Wash. Ave**

17. (a) **Oregon Co., Mo.** (b) Date thereof **Nov. 24 1947**
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation **BAILEY CEM. Oregon Co.**

18. (a) Signature of funeral director **Neal Thompson**
(b) Address **West Plains, Mo.**

19. (a) **Dec 1-1947** (b) **Beatrice Cook**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **22,** year **1947** hour **A:** minute **20 P. M.**

21. I hereby certify that I attended the deceased from **22 Nov 1947** to **22 Nov 1947** that I last saw him alive on **22 Nov 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Due to **Arterial Hypertension**

Due to **Arterial Hypertension**

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations **None**
Of autopsy **None**

27. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **None**
(b) Date of occurrence **None**
(c) Where did injury occur? (City or town) (County) (State) **None**
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **None**

23. Signature **Neal Thompson** (M. D. or other) **W. N.**
Address **West Plains, Mo.** Date signed **25/1/47**

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

MOTHER FATHER

RECEIVED

District Officer No. 5,
District File No. 1247695
Date Filed 12.13.47

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.....

Harold E. Hendrel

Registered Apprentice No. 26

working under my personal supervision.

Signed *Hal Thomburgh*

Licensed Embalmer No. 3408

P. O. Address *West Plains, 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. 100
Registrar's No. 47

Registration District No. 141 Primary Registration District No. 3025

1. PLACE OF DEATH:
(a) County Haskell
(b) City or town West Plains
(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
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 Samuel E. McClanahan
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1942 hour _____ minute _____ M. _____
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex M 5. Color or race W
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 May 7 (Month) 1902 (Day) 1902 (Year)
8. AGE: Years 54 Months _____ Days _____ If less than one day hr. _____ min. _____
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation Not working

11. Industry or business None

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

MOTHER FATHER
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)

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) _____ (c) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (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)

SUPPLEMENTARY 2

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

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

S-37936