

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 10 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11589**
Registrar's No. **496**

Registration District No. **42** Primary Registration District No. **1000**

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:
Sisters Hospital (St. Joseph's Hospital)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days**
In this community **7 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Kansas** (b) County **Doniphan 999**
(c) City or town **Troy** (If outside city or town limits, write "RURAL") **11**
(d) Street No. **Troy** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No) **2**
If yes, name country

3. (a) PRINT FULL NAME **Teressa B. McClelland**
(b) If veteran, name war **no** (c) Social Security No. **none**
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Chas E. McClelland** 6. (c) Age of husband or wife if alive **90** years
7. Birth date of deceased **Aug 23, 1861**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **21** year **1948** hour **11** minute **50** a. M.
21. I hereby certify that I attended the deceased from **3-12** 1947, to **4-23** 1948
that I last saw her alive on **April 21** 1948 and that death occurred on the date and hour stated above.

Immediate cause of death **myocardial infarction due to atherosclerosis**
release of blood clots from edema of heart failure
Duration **2 mo**

8. AGE: Years Months Days If less than one day
86 **7** **28** hr. min.
9. Birthplace **Troy Kansas**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Due to
Other conditions **none**
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy **97**

MOTHER FATHER
11. Industry or business
12. Name **Unknown**
13. Birthplace **unknown unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown unknown**
(City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. Marie Euler**
(b) Address **Troy, Kansas**
17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **4/21/48**
(Month) (Day) (Year)
(c) Place: burial or cremation **Troy, Kansas**
18. (a) Signature of funeral director **[Signature]**
(b) Address **Troy, Kansas**
19. (a) **May 3, 1948** (Date received local registrar) (b) **G. G. Jenkins** (Registrar's signature)

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) (c) Means of injury
23. Signature **[Signature]** (M.D. or other) **MD**
Address **[Address]** Date signed **4/21/48**

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

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.....

E. J. Kavan

Licensed Embalmer No. *3532*

P. O. Address. *Troy Kavan*

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.