

Registration District No. **43**

Primary Registration District No. **3007**

**1. PLACE OF DEATH:**  
 (a) County **Butler**  
 (b) City or town **Poplar Bluff**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Poplar Bluff Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **Days**  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **Gary Lee McLain**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **0**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **April 9 1946**  
(Month) (Day) (Year)

8. AGE: Years **2** Months **3** Days **21** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Dexter, Missouri**  
(City, town, or county) (State or foreign country)  
 10. Usual occupation **Child**

**MOTHER FATHER**  
 12. Name **Charles McLain**  
 13. Birthplace **Bloomfield, Missouri**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Lois Temples**  
 15. Birthplace **Dexter, Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lois McLain**  
 (b) Address **Bloomfield, Missouri**  
 17. (a) **Burial** (b) Date thereof **8-1-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Bloomfield Cemetery**

18. (a) Signature of funeral director **Chiles Und. Co.**  
 (b) Address **Bloomfield, Missouri**  
 19. (a) **8/5/48** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County **Stoddard** **103**  
 (c) City or town **Bloomfield**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month **July** day **30**  
 year **1948** hour **5** minute **30** **A.M.**  
 21. I hereby certify that I attended the deceased from **July 29**, 19**48** to **July 30**, 19**48**  
 that I last saw him alive on **July 30**, 19**48**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Toxic Bronchitis** **2 day**  
 Duration \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 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?  
 While at work? \_\_\_\_\_ (Specify type of place)  
 Signature **Frank E. Smith** (M. D. or other) **MD**  
 Address **Poplar Bluff** Date signed **Aug 3-48**

RECEIVED

District Health Office No. 2,

District File Number 848-102

Date Filed 8-16-44

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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 Lulu Cooper .....

.. Licensed Embalmer No. 3499 .....

P. O. Address Bloomfield, 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.