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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 7 1949

State File No. 39867

BIRTH NO. _____ REG. DIST. NO. 323' PRIMARY REG. DIST. NO. 4477 Registrar's No. 49

1. PLACE OF DEATH
a. COUNTY: SCHUYLER
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GLENWOOD
c. LENGTH OF STAY (In this place): 98
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: SCHUYLER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GLENWOOD
d. STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print)
a. (First): Laura
b. (Middle): Edith
c. (Last): McClellan

4. DATE OF DEATH (Month) (Day) (Year): Dec 1 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 21, 1895
9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: J. Harris Kelley
13b. MOTHER'S MAIDEN NAME: Ada Kitterman
14. NAME OF HUSBAND OR WIFE: Frank McClellen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Mr. Frank McClellen
ADDRESS: Glenwood

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: 5810

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. High Blood Pr.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec, 1948, *to* Nov 29, 1949, *that I last saw the deceased alive on* Nov 29, 1949, *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R E Vaughn D.O
23b. ADDRESS: Lancaster Mo
23c. DATE SIGNED: 12/3/49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: DEC 4, 49
24c. NAME OF CEMETERY OR CREMATORY: IOOF
24d. LOCATION (City, town, or county) (State): GLENWOOD MO

DATE REC'D BY LOCAL REG.: Dec. 3, 1949
REGISTRAR'S SIGNATURE: Mrs. R. J. Drake
25. FUNERAL DIRECTOR'S SIGNATURE: Everett R Head
ADDRESS: Lancaster Mo

(Licensed Embalmer's Statement on Reverse Side)

DEC 5 1949

RECEIVED
District Health Officer No. 10
District File Number 12-49-2006
Date Filed DEC 5 1949

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 ..... Student Embalmer No. ..... working under my personal supervision.

Student .....
Student Embalmer

Signed Everett R. Head

Licensed Embalmer No. H038

P. O. Address Lancaster, 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.