

FILED FEB 8-1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1215**
309

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | | c. LENGTH OF STAY (in this place) 35yrs | | c. CITY OR TOWN Kansas City | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hosp | | | | STREET ADDRESS (If rural, give location) 3518 3809 Walnut | | | |
| 3. NAME OF DECEASED (Type or Print) EFFIE | | a. (First) | | b. (Middle) McC | | c. (Last) McCLELLAN | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH July 31 1862 | |
| 9. AGE (in years last birthday) 92 | | IF UNDER 1 YEAR Months | | IF UNDER 1 YEAR Days | | IF UNDER 12 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and State or Foreign Country) Illinois | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13a. FATHER'S NAME Marion Francis Wood | | 13b. MOTHER'S MAIDEN NAME Alice Gray Cunningham | |
| 14. NAME OF HUSBAND OR WIFE Charles W McClellan | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT'S SIGNATURE OR NAME Miss Marion McClellan | | | | ADDRESS 3809 Walnut | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | | | | | |
| 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| ANTECEDENT CAUSES | | DUE TO (b) Fractured hip | | | | | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (c) | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | E9030 20 | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City Jackson, Mo. | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1-9-55 | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? fell on floor. | | | |
| 22. I hereby certify that I attended the deceased from _____, 19 <u>32</u> , to <u>1-22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>55</u> , and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE D. R. Black (Degree or title) | | | | 23b. ADDRESS 94 PM Bldg MD | | 23c. DATE SIGNED 1-23-55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 1-23-55 | | 24c. NAME OF CEMETERY OR CREMATORY Valhalla Cem | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo | |
| DATE REC'D BY LOCAL REG. 1-23-55 | | REGISTRAR'S SIGNATURE Neva Minshall | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stine & McClure K.C. Mo. | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

8481

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.....
Signature of Student Embalmer

Signed *Elmo D. Ingle*

Licensed Embalmer No. *481*

P. O. Address *Kansas City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.