

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF THE STATE OF MICHIGAN
STANDARD CERTIFICATE OF DEATH

State File No. **3643**

BIRTH NO.		REG. DIST. NO. 381		PRIMARY REG. DIST. NO. 4315		Registrar's No. 116	
1. PLACE OF DEATH a. COUNTY Sullivan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Sullivan			
b. CITY OR TOWN Milan		c. LENGTH OF STAY (in this place) 83 yrs		c. CITY OR TOWN Milan		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				e. STREET ADDRESS (If rural, give location) 1050 0			
3. NAME OF DECEASED (Type or Print) a. (First) Bertha			b. (Middle) L		c. (Last) McClary		4. DATE OF DEATH (Month) (Day) (Year) 1 30 - 55
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 1-7-1872		9. AGE (In years last birthday) 83	Months 0	Days 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Milan Mo		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Robert McClary			13b. MOTHER'S MAIDEN NAME Maryann Cochran		14. NAME OF HUSBAND OR WIFE		
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.		17. INFORMANT'S SIGNATURE OR NAME Robert Wilson		ADDRESS Milan Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia ANTECEDENT CAUSES Hypertrophic arthritis & advanced arteriosclerosis DUE TO (b) dehydratation, with unqualified cardiac syndrome DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Small bowel obstruction, malnutrition, dehydration, with unqualified cardiac syndrome					INTERVAL BETWEEN ONSET AND DEATH 6 days 40-50yrs	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 7230					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.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-11-55 , to 1-30-55 , 19 55 , that I last saw the deceased alive on 1-30-55 , and that death occurred at 3:50 am. , from the causes and on the date stated above.							
23a. SIGNATURE Joseph E. P... DO (Degree or title)				23b. ADDRESS 217 E. Second St., Milan, Mo		23c. DATE SIGNED 2-1-55	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 1-31-55	24c. NAME OF CEMETERY OR CREMATORY Oakwood Cem.		24d. LOCATION (City, town, or county) (State) Milan Mo		
DATE REC'D BY LOCAL REG. 2-1-1955		REGISTRAR'S SIGNATURE Mrs. H. B. Harris		25. FUNERAL DIRECTOR'S SIGNATURE Joseph Schene		ADDRESS Milan Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

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

Student.....
Signature of Student Embalmer

Signed..... *Dwight Schone*

Licensed Embalmer No. *2667*

P. O. Address *Milan*

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.