

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33381**
4346

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 Stoddard			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 10 Mo.		c. CITY OR TOWN Spickard		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Elms Nursing Home				STREET ADDRESS (If rural, give location) 0 4001			
3. NAME OF DECEASED (Type or Print) RUTH		a. (First)		b. (Middle) MC CLANAHAN		c. (Last)	
4. DATE OF DEATH 10-10-55		(Month)		(Day)		(Year)	
5. SEX Fe.		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 2-22-1876	
9. AGE (In years last birthday) 79		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) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Dr. Cecil Mc Clanahan			
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. Robert Mc Clanahan K. C. Mo.			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident with long prior hemiplegia ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Cerebral arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic head disease				INTERVAL BETWEEN ONSET AND DEATH 10 days 331X	
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.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY. (Month) (Day) (Year) (Hour) (m.)		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 <u>Feb 1</u> , 19 <u>55</u> , to <u>Oct. 10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>55</u> , and that death occurred at <u>1:45</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE E. G. Kettner (Degree or title) M.D.				23b. ADDRESS Kansas City, Mo.		23c. DATE SIGNED 10/10/55 (State)	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-10-55		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Spickard, Mo.	
DATE REC'D BY LOCAL REG. 10-10-55		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Freeman Mortuary K. C. Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

820 Prof. Kelly

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 *J. H. Freeman*

Licensed Embalmer No. *29*
P. O. Address *F. O.*

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.