

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1957

32011

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4266

300
-57

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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		Length of stay in lb 5 yrs.	d. STREET ADDRESS (If outside, give location) 2013 E. 12th Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Velvo Middle McClain Last McClain			4. DATE OF DEATH Month Sept. Day 11, Year 1957		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/3/1910	9. AGE (In years last birthday) 47		IF UNDER 1 YEAR Months 4 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Att.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Muskogee, Oklahoma	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charles McClain	13b. MOTHER'S MAIDEN NAME Rosanna Williams	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.II	16. SOCIAL SECURITY NO. 512-01-9546	17. INFORMANT Address Anna McClain, mother 2812 N. 7th KCK
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis.		INTERVAL BETWEEN ONSET AND DEATH 5870
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral thrombosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour 11:30 Month A Day 11 Year 57 a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 9-6-57 to 9-11-57 and last saw her alive on 9-11-57 Death occurred at 11:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) [Signature] MD	22b. ADDRESS 600 East 22nd Street	22c. DATE SIGNED 9-12-57
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23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/14/1957	23c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Kansas
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24. FUNERAL DIRECTOR ADDRESS Mrs. J.W. Jones Funeral Home 440 State K.C.K.	25. DATE RECD. BY LOCAL REG. 9-13-57	26. REGISTRAR'S SIGNATURE [Signature]
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

W.R. Peters ON

All diseases in Part I must be causally related.

KP
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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

Signature *Ernest English*

Licensed Embalmer No. *4105*
P. O. Address *4701 St. ...*

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.