URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 23 1960

60-030973
STATE FILE NUMBER

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 174

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Jasper
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Carthage — Length of stay in 1b: 17 hrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: McCune Brooks Hosp. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jasper
c. CITY OR TOWN: Carthage Rt. # 4 — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Rural Rt. # 4 — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Dixie Middle: Pearl Last: McLain
4. DATE OF DEATH: Month: August Day: 11 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10-25-79
9. AGE (last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (City and state or country): Route # 4 Carthage Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Laban C. Davis
13b. MOTHER'S MAIDEN NAME: Martha Largent
14. NAME OF HUSBAND OR WIFE: Hugh McLain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 493-40-9210
17. INFORMANT: V.D. McLain Address: -Rt.4 Carthage

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arterio-sclerotic hypertension — 5 yrs
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7-29-60, to 8-10-60 and last saw her alive on 8-10-60
Death occurred at 12:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: M. Foster Whitten (Degree or title) M.D.
22b. ADDRESS: Carthage, Missouri
22c. DATE SIGNED: 8-12-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8-13-60
23c. NAME OF CEMETERY OR CREMATORY: Forest Park Cemetery
23d. LOCATION (City, town, or county) (State): Joplin, Missouri

24. FUNERAL DIRECTOR ADDRESS: Ulmer Funeral Home-Carthage, Mo.
25. DATE RECD. BY LOCAL REG.: 8-15-60
26. REGISTRAR'S SIGNATURE: C M Clinton

(Licensed Embalmer's Statement on Reverse Side)

SEP 6 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. #955

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.