URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 14 1960

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 438 =60=037700 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY: Cape Girardeau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Cape Girardeau — Length of stay in 1b: 3days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Southeast Missouri Hos. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY: Cape Gir.
c. CITY OR TOWN: Jackson — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): Greensferry Rd. — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Beth Middle: Ellen Last: McClard

4. DATE OF DEATH: Month: Nov. Day: 2 Year: 1960

5. SEX: Fe
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Oct30,60
9. AGE (last birthday): IF UNDER 1 YEAR: Months: Days: 3 IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Cape Girardeau, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Wayne McClard
13b. MOTHER'S MAIDEN NAME: Madge Roloff
14. NAME OF HUSBAND OR WIFE: None

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.: None
17. INFORMANT: Wayne McClard Address: Jackson, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Precipitate labor + delivery
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Interventricular septal defect

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 Oct 30, 1960 to Nov 2, 1960 and last saw her ~~him~~ alive on Nov 2, 1960
Death occurred at 10:45 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. N. Jaeger (Degree or title): M.D.
22b. ADDRESS: Jackson, Mo
22c. DATE SIGNED: Nov 4, 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov. 3, 1960
23c. NAME OF CEMETERY OR CREMATORY: Russell Heights
23d. LOCATION (City, town, or county) (State): Jackson Missouri

24. FUNERAL DIRECTOR: G. C. Crawford ADDRESS: Jackson, Mo.
25. DATE RECD. BY LOCAL REG.: 11-9-1960
26. REGISTRAR'S SIGNATURE: Irma Karten

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4327

P. O. Address

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