

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-012294

STATE FILE NUMBER

Registration District No. 38-1 Primary Registration District No. 4515 Registrar's No. 22

AMENDED

FILED MAR 20 1961

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| 1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SULLIVAN</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN</u> | Length of stay in 1b <u>65 YRS</u> | c. CITY OR TOWN <u>MILAN</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SULLIVAN CO MEMORIAL HOSPITAL</u> | | d. STREET ADDRESS (If outside, give location) | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>OPAL ELIZABETH MCCLAREN</u> | | | 4. DATE OF DEATH Month Day Year <u>MAR 10 1961</u> | | | |
| 5. SEX <u>FE</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-4-88</u> | 9. AGE (last birthday) <u>73</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (City and state or country) <u>KANSAS</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | | |

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| 13a. FATHER'S NAME <u>LUCIEN ROWAN</u> | | 13b. MOTHER'S MAIDEN NAME <u>NANCY JANE GIBBONS</u> | | 14. NAME OF HUSBAND OR WIFE <u>SAM MCCLAREN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONIE</u> | 17. INFORMANT Address <u>MILLARD MCCLAREN PURDIA MO</u> | | |

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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> | | <u>3-10-61</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>cardiac neural symptoms</u> | <u>3 mo.</u> |
| | DUE TO (c) <u>Hypertension</u> | <u>3 mo.</u> |

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| 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. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | |

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|---|--|--|------------------------|--------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <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 <u>MILAN</u> | COUNTY <u>MILAN</u> | STATE <u>MO</u> |
| 21. I attended the deceased from <u>12-20-60</u> to <u>3-10-61</u> and last saw her ^{her} alive on <u>3-10-61</u> Death occurred at <u>2:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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| 22a. SIGNATURE <u>Earl Simpson D.O.</u> | (Degree or title) | 22b. ADDRESS <u>Milan</u> | 22c. DATE SIGNED <u>3-14-61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>3-12-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>HENRY</u> | 23d. LOCATION (City, town, or county) (State) <u>MILAN MO</u> |
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| 24. FUNERAL DIRECTOR <u>Raymond Thomas</u> | ADDRESS <u>Milan, Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>3-17-61</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u> |
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DATE PREPARED BY: _____
INSTEAD OF _____
SHOULD READ _____
BY AFFIDAVIT OF _____

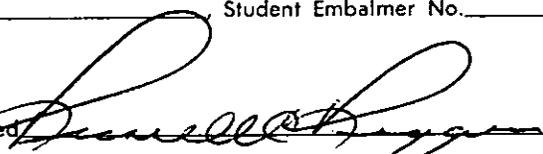
DOCUMENT

MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 3792

P. O. Address Milwaukee, Mo

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.