

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037797

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 237 Primary Registration District No. 3-804 Registrar's No. 46

FILED OCT 23 1961

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| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>MONROE</u> | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JACKSON</u> | a. STATE <u>MO</u> | b. COUNTY <u>MONROE</u> |
| Length of stay in 1b <u>9 1/2 yrs.</u> | | c. CITY OR TOWN <u>JACKSON TWP.</u> | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION <u>2 MI. E. OF PARIS, MO.</u> | | d. STREET ADDRESS (If outside, give location) <u>2 MI. E. OF PARIS, MO.</u> | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | | |
| First <u>LEWIS</u> | Middle <u>MNASON</u> | Last <u>McCLAIN</u> | Month <u>OCT.</u> | Day <u>18</u> | Year <u>1961</u> | |
| 5. SEX <u>M</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>3/4/1886</u> | 9. AGE (last birthday) <u>75</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> | IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL FARMING</u> | | 11. BIRTHPLACE (City and state or country) <u>MO. LEWIS, CO. U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY |
| 13a. FATHER'S NAME <u>BENJAMIN McCLAIN</u> | | 13b. MOTHER'S MAIDEN NAME <u>LUCINDA BOWEN</u> | | 14. NAME OF HUSBAND OR WIFE <u>NETA B. McCLAIN</u> | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi) <u>NO</u> | 17. INFORMANT Address <u>R 2</u> <u>NETA B. McCLAIN PARIS, 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 <u>7 1/2</u> |
| IMMEDIATE CAUSE (a) <u>Falling dead in</u> | DUE TO (b) <u>Stroke</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (c) <u>Chronic MI</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"/> No <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 <u>-</u> a.m. <u>-</u> p.m. Month, Day, Year | | |
| 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 COUNTY STATE |

21. I attended the deceased from _____ to _____ and last saw him alive on _____
Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>County Health Department</u> | 22b. ADDRESS <u>Paris, MO</u> | 22c. DATE SIGNED <u>10/18/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>OCT. 21 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LA BELLE CITY CEM.</u> |
| 24. FUNERAL DIRECTOR <u>E.H. AGNEW</u> | | 23d. LOCATION (City, town, or county) (State) <u>LABELLE MO.</u> |
| ADDRESS <u>PARIS, MO</u> | | 25. DATE RECD. BY LOCAL REG. <u>10-19-61</u> |
| 26. REGISTRAR'S SIGNATURE <u>E.A. Barnett M.D.</u> | | |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

APR 24 1962

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 E. H. Ognew

Licensed Embalmer No. 4000

P. O. Address Paris, 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.