

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047677
STATE FILE NUMBER

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 502

FILED JAN 16 1962

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar, Bluff, Mo</u>		c. CITY OR TOWN <u>Advance, Mo R#1</u>	
Length of stay in 1b <u>4 days</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Brandon Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>7 mi S.W.</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Henry McClain</u>			4. DATE OF DEATH Month Day Year <u>Dec 18, 1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>7-20-1887</u>
9. AGE (last birthday) <u>74</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>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cape County</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>Henry Patrick McClain</u>		13b. MOTHER'S MAIDEN NAME <u>Not known</u>	14. NAME OF HUSBAND OR WIFE <u>Rosa F McClain</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.	17. INFORMANT Address <u>Rosa F. McClain Advance, Mo R#1</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basal skull fracture due to auto accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
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)			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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Was caught between wagon and truck while unloading corn on a farm.</u>	
20c. TIME OF INJURY Hour <u>3:00</u> p.m. <u>12-14-61</u>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>on farm</u>	20f. CITY, TOWN, OR LOCATION <u>Advance</u>	COUNTY <u>Stoddard</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>12-14-61</u> to <u>12-18-61</u> and last saw ^{her} him alive on <u>12-18-61</u> Death occurred at <u>12:24</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. L. Brandon</u> (Degree or title)		22b. ADDRESS <u>1124 No. Main, Poplar Bluff</u>	22c. DATE SIGNED <u>1-9-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-20-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brown</u>	23d. LOCATION (City, town, or county) (State) <u>Puxico, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Morgan Funeral Home Puxico, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-12-1962</u>	26. REGISTRAR'S SIGNATURE <u>Shelma Graham</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AWIENCED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

HOW NO. SHOULD READ

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 _____
Signature of Student Embalmer

Signed _____

W^m H. Mary

Licensed Embalmer No. 4640

P. O. Address Advance

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.