

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

3599

1. PLACE OF DEATH
 100 County Scott Registration District No. 818
 Township _____ Primary Registration District No. 524
 City Dehlstadt (No. 4199) St. _____ Ward _____

2. FULL NAME Ruben Mc Clain
 (a) Residence, No. near Dehlstadt, Mo. St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. 4 1/2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>m</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 26th 1933</u>				
7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.	
	<u>2</u>	<u>24</u>		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Earle Arkansas</u>			
	13. NAME <u>Lee Mc Clain</u>			
FATHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Bisbee Arkansas</u>			
	15. MAIDEN NAME <u>Ruby Campbell</u>			
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Coppeville Miss</u>			
	17. INFORMANT <u>Lee Mc Clain</u> (ADDRESS) <u>Dehlstadt, Mo.</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Oak Grove</u> DATE <u>Jan 21, 1934</u>				
19. UNDERTAKER <u>Lain Ins. Co.</u> (ADDRESS) <u>202 Law Jr</u>				
20. FILED <u>Jan 20th 1934</u> <u>J. Stroman</u> Registrar.				

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-20 7:30 A.M. 1934

22. I HEREBY CERTIFY, That I attended deceased from but not have a doctor, 19____, 19____.
 I last saw h _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Catarhase Pneumonia
Following La Grippe
has given from history
of family
 Date of onset _____

Other contributory causes of importance: 11A 107A

Name of operation _____ Date of _____
 What test confirmed diagnosis? County Hospital Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Frank S. Norman M.D.
 (Address) Charleston Mo Registrar.

FEB 27 1934

