S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

SEP 5 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

27459
State File No.

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: N.E. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days (Specify whether years, months or days)

In this community 19 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Independence, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 1022 E Lexington
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Mrs. Oral J. McClain 245

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Delbert D. McClain

6. (c) Age of husband or wife if alive: 58 years

7. Birth date of deceased: May 30, 1886 (Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 1 If less than one day hr. min.

9. Birthplace (City, town, or county) Michigan (State or foreign country)

10. Usual occupation: Homemaker

11. Industry or business:

MOTHER FATHER

12. Name: Unknown

13. Birthplace (City, town, or county) Unknown (State or foreign country)

14. Maiden name: Unknown

15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Delbert D. McClain

(b) Address: Indep. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Floral Hills Cemetery.

18. (a) Signature of funeral director: C.H.Blackman & Son, Inc.

(b) Address: K.C.Mo.

19. (a) Aug. 2, 1940 (Date received local registrar) (b) M. M. Crome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from July 29, 1940, to July 31, 1940, that I last saw her alive on July 31, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia + Peritonitis associated with acute appendicitis in a cancerous

Due to: Thrombosis of Femoral Veins

Due to: Cancer

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: Pan hysterectomy July 27, 1940 Fibroid Uterus

Of autopsy: yes (Non Malignant)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature: F. P. Walker (M. D. or other)

Address: Richmond Hotel Date signed 8/1/1940

(Licensed Embalmer's Statement on Reverse Side)

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 _____

_____, Registered Apprentice No. _____,

working under my personal supervision.

Signed H D Blackman

Licensed Embalmer No. 3639

P. O. Address K C 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 this body is not embalmed, above space should be left blank.