

S. No. 2
M-542
v. 5-17-39
X32873

55042

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 23 1942

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9484

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Bonne Terre,
(If outside city or town limits, write "RURAL")
(d) Street No. 302 Hill St.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Clara Syrilda McClain

3. (b) If veteran, name war..... 3. (c) Social Security No. None

4. Sex Female / Color or race White
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife J. E. McClain
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased Sept. 18th 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 | 1 | 25 |hr.min.

9. Birthplace Bonne Terre, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER

12. Name H. Clay Thurman
13. Birthplace Unknown, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Gibbons
15. Birthplace Unknown, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. M. Cohoon
(b) Address 3054 Marcus Ave

17. (a) Burial (b) Date thereof 11-14-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre, Mo.

18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.

19. (a) NOV 13 1942 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 13
year 1942 hour 7 minute - M.

21. I hereby certify that I attended the deceased from OCT. 19
1942 to NOV 13 1942
that I last saw h. ER alive on NOV 13 1942
and that death occurred on the date and hour stated above.

Immediate cause of death menia
Due to anuria
Due to.....

Other conditions obstructive jaundice
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature Gilbert Bechtel M. D. o
Address Mo. Pac. Hosp. Date signed 11-13-42

APR 18 1944

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

J. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

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, fact should be so stated above.