

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32978

FILED SEP 24 1956

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 375 PRIMARY REG. DIST. NO. 6288 Registrar's No. ....

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

|  |                           |   |  |
|--|---------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Wright</u>   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo</u> b. COUNTY <u>Wright</u>  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Grove Springs Rt. 1</u>  |                           | c. LENGTH OF STAY (in this place) <u>1</u>  | c. CITY OR TOWN <u>Grove Spring Rt. 1</u><br>d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grove Springs Rt. 1</u>   |                           | e. STREET ADDRESS (If rural, give location) <u>Grove Springs Rt. 1 140</u>  |  |
| 3. NAME OF DECEASED<br>a. (First) <u>Myrtle</u> b. (Middle) <u>Lou</u> c. (Last) <u>McClanahan</u>   |                           | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 5 1956</u>   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>   | 8. DATE OF BIRTH <u>Jan. 31 1888</u>   |
| 9. AGE (In years last birthday) <u>68</u>  |                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>   |  |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>Webster Co. Mo.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  |
| 13a. FATHER'S NAME <u>Jessie Alford</u>  |                           | 13b. MOTHER'S MAIDEN NAME <u>Not Known</u>  | 14. NAME OF HUSBAND OR WIFE <u>Widd McClanahan</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'S SIGNATURE OR NAME ADDRESS <u>Widd McClanahan Grove Springs Rt. 1</u>   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  |                           | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Edema, acute</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u><br>ANTECEDENT CAUSES<br>DUE TO (b) <u>Cerebral Vascular accident</u> <u>5 min.</u><br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (c) <u>Cerebral &amp; General arteriosclerosis</u> <u>5-10 years</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Congestive Vascular heart disease</u> <u>6 months</u> |  |
| 19a. DATE OF OPERATION _____   |                           | 19b. MAJOR FINDINGS OF OPERATION _____  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           | 331.X   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____   |                           | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____  |                           | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21f. HOW DID INJURY OCCUR? _____   |
| 22. I hereby certify that I attended the deceased from <u>7/17<sup>th</sup></u> 19 <u>54</u> , to <u>9/5<sup>th</sup></u> 19 <u>56</u> , that I last saw the deceased alive on <u>9/1<sup>st</sup></u> 19 <u>56</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above. |                           |   |  |
| 23a. SIGNATURE <u>T. M. Macdonnell</u> (Degree or title) <u>M.D.</u>   |                           | 23b. ADDRESS <u>Marshfield</u>  |  |
| 23c. DATE SIGNED <u>9/17/1956</u>  |                           |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   |                           | 24b. DATE <u>9/5/56</u>   | 24c. NAME OF CEMETERY OR CREMATORY <u>Eureka</u>   |
| 24d. LOCATION (City, town, or county) (State) <u>Webster Co. Mo.</u>   |                           |   |  |
| DATE REC'D BY, LOCAL REG. <u>Sept. 18, 56</u>  |                           | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. R. Palmer Lebanon Mo.</u>  |  |
| REGISTRAR'S SIGNATURE <u>Donnie J. [Signature]</u>   |                           | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. R. Palmer Lebanon Mo.</u>  |  |

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(Licensed Embalmer's Statement on Reverse Side)

SEP 24 1956

RECEIVED Sept 22, 56  
WRIGHT CO. HEALTH DEPT.  
County File Number 956-92  
Date Filed Sept 22, 1956

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..... *S. R. Palmer*

Licensed Embalmer No. 220

P. O. Address..... *Libana*

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.