

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005757

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 17 STATE FILE NUMBER

FILED FEB 25 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Clinton</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cameron</u> Length of stay in 1b <u>40 Yr, 8</u></p> <p>c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cameron Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>Clinton</u></p> <p>c. CITY OR TOWN <u>Cameron Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>1001 W. 4th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
3. NAME OF DECEASED (Type or print) <u>John Lafayette McClain</u> First Middle Last	
4. DATE OF DEATH <u>Feb. 18 1963</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19 1871</u> 9. AGE (last birthday) <u>91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Chief Police</u>
11. BIRTHPLACE (City and state or country) <u>Virginia Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>William McClain</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ann Dodge</u>
14. NAME OF HUSBAND OR WIFE <u>Deceased</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. [REDACTED]	17. INFORMANT <u>Marjorie Baker</u> Address <u>Cameron, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>	INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary artery sclerosis</u> <u>5 yrs.</u>
	DUE TO (c) <u>Generalized arterio sclerosis</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Viral influenza</u>	
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 type="checkbox"/>	20a. ACCIDENT <input 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>10-2-53</u> to <u>2-18-63</u> and last saw him alive on <u>2-17-63</u>	
Death occurred at <u>10:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Cameron Mo</u>
	22c. DATE SIGNED <u>2/19/63</u>
23a. BURIAL, CREMATION, REMAINS <u>Buried</u>	23b. DATE <u>Feb. 23 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Garden Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Garden Grove, Iowa</u>
24. FUNERAL DIRECTOR <u>Poland Funeral Home</u> ADDRESS <u>Cameron, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-21-63</u>
	26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

1 0251

2 0251

3 7

4 0

5 2

6

7 1

8 0

9 4201

10

11

12 86-2

13 2-0

2-18-62

2-19-63

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 Robert L. Coland

Licensed Embalmer No. 4777
22 1/2 West 3rd St.
P. O. Address Camden Mo

Permit issued 2-21-63

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.

[Faint handwritten notes at the bottom left]