

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7346

State File No.

FILED MAR 12 1945

Registration District No. 228

Primary Registration District No. 6148

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
 (b) City or town Bell City, Route # 1
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: None Casor Camp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community Months
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard
 (c) City or town Bell city R # 1. 103
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Ida McClanahan

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife L. K. Mc Clanahan 6. (c) Age of husband or wife if alive: _____ years
 7. Birth date of deceased July 27, 1883
 (Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Scott co. Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER } 12. Name W. M. Holaway
 13. Birthplace _____ Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Thompson
 15. Birthplace _____ Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant L. K. McClanahan

(b) Address Bell City, Mo. Route # 1

17. (a) Burial (b) Date thereof Feb. 3-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Morley cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) Feb. 8th 1945 (b) Pearl E Luone
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31st
 year 1945 hour 6:50 minute P. M.
 21. I hereby certify that I attended the deceased from Jan. 30th 1945 to Jan. 31st 1945
 that I last saw her alive on Jan. 30th 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumoniae oide.

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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 C. O. Bennett (M. D. or other)
 Address Bell City, Mo. Date signed 7/31/1945

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

1130

RECEIVED

District Health Office No. 2,

District File Number 345-397

Date Filed 3/8/45

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.

Signature John C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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, fact should be so stated above.