

**MISSOURI STATEBOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

36565

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 131
Township Randolph Primary Registration District No. 5182
City Cape Girardeau St. _____ Ward _____

2. FULL NAME

(a) Residence No. J. A. McLean St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs J. A. McLean

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 29 - 1861

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
67	10	10	

8. OCCUPATION OF DECEASED 82A Merchant
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cape County
(STATE OR COUNTRY) Mississippi

10. NAME OF FATHER John McLean

11. BIRTHPLACE OF FATHER (CITY OR TOWN) North Carolina
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lucie McLaughlin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)

14. INFORMANT Mr. J. J. McLean
(Address) R. F. D. #1

15. FILED 10, 1929 Oliver Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 8 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy caused by hemorrhage of brain - low

CONTRIBUTORY (SECONDARY) 74A (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas. B. Jay M.D.
(Address) Jackson 210

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL McClain Cemetery DATE OF BURIAL Nov. 10 1929

20. UNDERTAKER W. B. DeWitt ADDRESS 536 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

