

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

31919

File No. _____
Registered No. **8940**
St. _____ Ward)

1. PLACE OF DEATH

County..... Registration District No. 735
Township..... Primary Registration District No. 7000
City St. Louis mo (No. _____)

2. FULL NAME

Warren Dean McClard
(a) Residence. No. 1410 Dillon St., 23 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. 5 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 (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29 - 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
5 | 5 | 5 | 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Chester W. McClard
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Burfordville mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Minnie Sutton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jonesburg Mo.
(STATE OR COUNTRY)

14. INFORMANT Minnie Sutton
(Address) 1410 Dillon

15. FILED Map C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 to Sept 2 1929 that I last saw him alive on Sept 2 1929 and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spina bifida
congenital
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) E. M. Adams, M. D.

Sept 3, 1929 (Address) 3012 Lafayette
*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 St Mathews Cemetery DATE OF BURIAL 9-3 1929

20. UNDERTAKER McLaughlin ADDRESS 1631 Mo. ave

WRITE PAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

