

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

**32337**

Do not use this space.

**1. PLACE OF DEATH**

(a) County..... *X* Registration District No. **791**  
 (b) Township..... Primary Registration District No. **1003**  
 (c) City **St. Louis, Missouri** (d) Street No. **City Hospital No. 1** Registered No. **8391**  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**C7577**

**2. PRINT FULL NAME**

**Alexander McLachlan**

(a) Residence, No. **no home** St. **[Y]**  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**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) **unk.**  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**47** **?** **?**  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. **salesman**  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **England**

FATHER 13. NAME **UNKNOWN**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **UNKNOWN**

MOTHER 15. MAIDEN NAME **UNKNOWN**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **UNKNOWN**

17. INFORMANT **Hosp. Info M. Kent**  
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **NEW ORLEANS, LA.** DATE **9-7-37**, 19..

19. FUNERAL DIRECTOR (ADDRESS) **MULLEN BROS.**  
**4259 WINDELL BLVD**

20. FILED **SEP 7 1937** **J. Bredeck**  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9/3/37**, 19..  
 22. I HEREBY CERTIFY, That I attended deceased from **8/27/37**, 19.. to **9/3/37**, 19..  
 I last saw him alive on **9/3/37**, 19.. Death is said to have occurred on the date stated above, at **7.30 a. p.**  
 The principal cause of death and related causes of importance were as follows:

**Thrombocytopenic Purpura Essential**

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19..  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....  
 (Signed) **Edmund P. Vieth**, M. D.  
 (Address) **City Hospital No. 1**

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.

STATEMENT BY LICENSED EMBALMER

I, H. E. Burgess, Licensed Embalmer No. 3547  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself  
L. E.  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed H. E. Burgess  
Licensed Embalmer No. 3547

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.)