

JAN 12 1940

701
1003

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County 2
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4929 Terry Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 60 yrs. years, months or days)

3. (a) PRINT FULL NAME Jane R. McClelland 2443. (b) If veteran, name war _____ 3. (c) Social Security No. None4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Wid.6. (b) Name of husband or wife Thomas McClelland 6. (c) Age of husband or wife if alive Decd. years7. Birth date of deceased June 3rd, 1851
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
88 5 27 hr. _____ min.9. Birthplace England
(City, town, or county) (State or foreign country)10. Usual occupation Housework

11. Industry or business _____

12. Name John Smith13. Birthplace England
(City, town, or county) (State or foreign country)14. Maiden name Jane Lindo15. Birthplace England
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Charles Comfort(b) Address 4929 Terry Ave.17. (a) Burial (b) Date thereof 12-2-39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Bellefontaine Cem.18. (a) Signature of funeral director Thorst Ued Co(b) Address 10 N. Grand Blvd.19. (a) DEC 1 1939 (b) J. P. Brueck
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County 1
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")
(d) Street No. 4929 Terry Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 75 Yrs. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30th.
year 1939 hour 6.00 minute P. M.21. I hereby certify that I attended the deceased from March 15, 1939, to Nov. 30, 1939;
that I last saw her alive on Nov. 29, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death:

Chronic Bronchitis

Duration

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Chronic Myocarditis

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 H. A. White (M. D. or other) MD
Address 1511 E Grand St Date signed 12/4/39

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.

H. G. Whelan
1511 S. Grand
9-10
Am 9222

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Philip L. Frankman

Licensed Embalmer No. 3553

P. O. Address 3710 N. Grand Blvd.

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, above space should be left blank.