

Registration District No. 284

Primary Registration District No. 117

Registrar's No. 480

APR 8 1940

1. PLACE OF DEATH:

(a) County St. Louis,
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Bethesda Dillworth Home.
(If not in hospital or institution, write street number or location) 3
(d) Length of stay: In hospital or institution 1-2 Years
(Specify whether
In this community
years, months or days) 2 11 P

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Webster Groves,
(If outside city or town limits, write "RURAL")
(d) Street No. 1001 Big Bend Road.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME CAROLINE McLean

8. (b) If veteran, name war none 8. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 28 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 7 9 hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Music teacher

11. Industry or business _____

12. Name Alexander Mc Lean.

18. Birthplace Scotland
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Griffith.

15. Birthplace Scotland
(City, town, or county) (State or foreign country)

16. (a) Informant L.A. McLean

(b) Address 5728 Julian,

17. (a) Burial (b) Date thereof 3/9/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cemetery

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) MAR 7 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7th
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Nov. 1938 to Mar 7 1940
that I last saw her alive on Mar. 6 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Branches pneumonia Duration 4 d.
Hemiplegia (Left) 1937
(Subacute)

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? _____

707
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]

Address [Signature] Date signed _____

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

107A

105 - W. Rockwood (Mudate)
3-5-
Holt 502 /
(Grove + Fairwood)

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.

Signed Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address St Louis 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12458

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. 750

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

1. PLACE OF DEATH

(a) County St. Louis

(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Caroline McLean

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced -

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one year
				hr. min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____ (City, town, or county) (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month Mar. day 7 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis pneumonia

Due to Neuriplegia Lt. Central Squamous (Clt)

Due to _____

Other conditions (include pregnancy within 3 months of death) 87a1

Major findings: Of operations _____

Of autopsy _____

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 J. Seabough (M. D. or other) _____

Address 00 Date signed _____

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

1940
S-12458

7/11