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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16872

JUN 15 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4350

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St. Louis 20 (If outside city or town limits, write "RURAL")

(d) Street No. 1823 Cass Ave. (If rural, give location)

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

3. (a) PRINT FULL NAME Mary McLean 245

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Nil

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased Sept (Month) 20th. (Day) 1872 (Year)

8. AGE: Years 67 Months 7 Days 24 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name John McLean
13. Birthplace (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Margaret Mahoney
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant's own signature John P McLean

(b) Address 1823 Cass Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/40 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemt

18. (a) Signature of funeral director Harrigan & Sheahan Und Co

(b) Address 4415 Washington Blvd.

19. (a) MAY 16 1940 (Date received local registrar) (b) J. P. Burdick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 14th. day May year 1940 hour 8:35 A.M. minute M.

21. I hereby certify that I attended the deceased from April 15, 1940, to May 14, 1940; that I last saw her alive on May 14, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute dilatation of Heart	2 days
Due to: a Hypostatic Pneumonia unspecified	
Due to: Pernicious anemia	30 da
Due to: no definite heart disease	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 71a	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature B. F. Sliegel (M. D. or other)

Address 1878 Madison Date signed 5-13-40

(Licensed Embalmer's Statement on Reverse Side)

Dr Strieg
14th & Madison
9-2 2-3
6-8

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 Homer W. Fritz

Licensed Embalmer No. 3882

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.