

Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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17
9

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: **Firmen Desloge 13**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **Wanda Darlene Mc Clure**

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

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

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

7. Birth date of deceased **May 29 1941**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **10** hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Frederick Laungal Mc Clure**
13. Birthplace **St Louis** (City, town, or county) **MO** (State or foreign country)
14. Maiden name **Gerlean Mae Conner**
15. Birthplace **Wassalla** (City, town, or county) **MO** (State or foreign country)

16. (a) Informant **Gerlean Mc Clure**

(b) Address **6307 Lemox, Wellston Mo**

17. (a) **Burial** (b) Date thereof **5/31/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wassalla Mo**

18. (a) Signature of funeral director **John W. Clark**

(b) Address **1125 Hopkins mart ave**

19. (a) **MAY 30 1941** (Date received local registrar) (b) **J. T. Medved** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Louis**
(c) City or town **Wellston** (If outside city or town limits, write "RURAL") **Mo**
(d) Street No. **6307 Lemox** (If rural, give location)
(e) If foreign born, how long in U. S. A.? **1** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **29** year **1941** hour **110** minute **P.** M.

21. I hereby certify that I attended the deceased from **12 noon** **5-29**, 19 **41**, to **10 PM 5-29**, 19 **41** that I last saw her alive on **5-29**, 19 **41** and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity**

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? _____

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

23. Signature **William H. Clark** (M. D. certifier) **0**

Address **330 Metropolitan Bldg** Date signed **5-30-41**

Embalmed

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.

[Handwritten signature]

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.