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7-39
X28390

AUG 8 1941

Registration District No. **84**

Primary Registration District No. **181**

Registrar's No. **1569**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**

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

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

(d) Length of stay: In hospital or institution **60 YEARS** (Specify whether years, months or days)

In this community **60 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **ST. LOUIS 96**

(c) City or town **CLAYTON 2**
(If outside city or town limits, write "RURAL")

(d) Street No. **415 ARBOR ROAD 3**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country **0**

3. (a) PRINT FULL NAME **FRANK P. McCLELLAN**

3. (b) If veteran, name war

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **27** year **1941** hour **6** minute **A.** M.

4. Sex **MALE 0**

5. Color or race **WHITE**

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

6. (b) Name of husband or wife **LUCIA F. McCLELLAN**

6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **JAN. 23 1881**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 27 1941** to **July 27 1941**

that I last saw him **alive on July 27 1941** and that death occurred on the date and hour stated above.

Immediate cause of death **myocardial infarction**

Duration **20 years**

8. AGE: Years **60** Months **6** Days **4** If less than one day **hr. min.**

Due to **Chronic Arthritis Deformans**

Due to **Chronic Devald's Peritonitis**

Other conditions **past 20 years**
(Include pregnancy within 3 months of death)

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

10. Usual occupation **RETIRED GRAIN DEALER**

Major findings:
Of operations **598**

Of autopsy

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

MOTHER FATHER { 11. Industry or business

12. Name **JAMES S. McCLELLAN**

13. Birthplace **ILLINOIS**
(State or foreign country)

14. Maiden name **MARY FINLEY**
(State or foreign country)

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

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?

16. (a) Informant **MRS. LUCIA McCLELLAN**

(b) Address **415 ARBOR ROAD (CLAYTON MO.)**

17. (a) **BURIAL** (b) Date thereof **7-29-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY CEMETERY**

18. (a) Signature of funeral director **Arthur Donnelly**
3840 LINDELL BLVD.

(b) Address

19. **JUL 28 1941** (Date received local registrar)

J. R. Meyer (Registrar's signature)

While at work? (Specify type of place)

(e) Means of injury

23. Signature **Arthur Donnelly** (M. D. or other)

Date signed **7-28-41**

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

DeLuter 1984

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 *William Matre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.