

National Office of Vital Statistics

State File No. ....

FILED OCT 2 1948

2101

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. ....

## 1. PLACE OF DEATH:

(a) County ST LOUIS  
 (b) City or town PINE LAWN  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
SHAMROCK HOME 4  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 yrs  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARY McCLelland3. (b) If veteran, - 3. (c) Social Security No. ....  
name war .....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married 2  
 divorced 2  
 6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if  
 alive ..... years 4  
 7. Birth date of deceased unknown  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
about 78 ..... hr. .... min.9. Birthplace unk. 9  
(City, town, or county) (State or foreign country)10. Usual occupation nil11. Industry or business -12. Name do not know13. Birthplace do not know 9  
(City, town, or county) (State or foreign country)14. Maiden name do not know15. Birthplace do not know 9  
(City, town, or county) (State or foreign country)16. (a) Informant Shamrock Rest Home(b) Address Pine Lawn, Mo17. (a) Burial (b) Date thereof 9/9/48  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Free Free Cem.18. (a) Signature of funeral director Peterson Funeral Home(b) Address 2722 Oakland Overland Mo19. (a) 9/15/48 (b) Cecil A. Z. Shay MO  
(Date received local registrar) (Registrar's signature)20. DATE OF DEATH: Month Sept day 5  
year 1948 hour ..... minute 2 P.M.21. I hereby certify that I attended the deceased from Feb 1 1946 to Sept 5 1948  
that I last saw her alive on Sept 3 1948  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral thrombosis 2 days  
Arteriosclerotic Cardiovascular Disease 5 yrs  
Due to 93d

Other conditions (include pregnancy within 3 months of death)

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? (Specify type of place)  
While at work? (e) Means of injury ?)23. Signature Lewis Pittman (M. D. or other) MO  
Address 4231 Clayton Rd Date signed 9/15/48

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5  
year 1948 hour ..... minute 2 P.M.21. I hereby certify that I attended the deceased from Feb 1 1946 to Sept 5 1948  
that I last saw her alive on Sept 3 1948  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral thrombosis 2 days  
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(a) Accident, suicide, or homicide (specify) .....  
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While at work? (e) Means of injury ?)23. Signature Lewis Pittman (M. D. or other) MO  
Address 4231 Clayton Rd Date signed 9/15/48

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

*Al C. Outman*

Licensed Embalmer No. *3478*

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.

Registration District No. 277

Primary Registration District No. 6076

Registrar's No. 270/r

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town Pinckney  
 (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 \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME

Mary McClelland

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

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

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 79 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Duration \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-31453