

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 19 1949

State File No. **10348**
Registrar's No. **2273**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 8106 Minnesota	

3. NAME OF DECEASED (Type or Print) Martha McClain			4. DATE OF DEATH (Month) (Day) (Year) Mar 6 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec-14-1875	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 2 Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Potosi Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Quillian	13b. MOTHER'S MAIDEN NAME Francis Bohannan	14. NAME OF HUSBAND OR WIFE John William McClain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Hebert McClain ADDRESS St. Louis, Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Central thrombus of left middle cerebral artery DUE TO (b) hypertensive cardiovascular disease DUE TO (c) general arteriosclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. psychoneurosis, hypochondriasis, psychoneurosis, hypochondriasis		2 yrs
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION psychoneurosis		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **7:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul M. Cardwell M.D.	23b. ADDRESS	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar-9-1949	24c. NAME OF CEMETERY OR CREMATORY Bonne Terre Cemetery	24d. LOCATION (City, town, or county) (State) Bonne Terre, Missouri
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DATE REC'D BY LOCAL REG. 3-12-49	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Sparks ADDRESS Flat River, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

22223

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Murphy L. Spaulding

Licensed Embalmer No. 4236

P. O. Address Flat River, Me

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.