

No. 300
10. 48

FILED APR 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11048**
Registrar's No. **309**

96000
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY OR TOWN Wellston		c. CITY OR TOWN Wellston	
d. FULL NAME OF HOSPITAL OR INSTITUTION 216 Buckner Avenue		d. STREET ADDRESS (If rural, give location) 1216 Buckner Avenue	
3. NAME OF DECEASED a. (First) Frank b. (Middle) G. c. (Last) McClinton			4. DATE OF DEATH Mar. 8, 1949
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) D.	8. DATE OF BIRTH Aug. 18, 1883
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME Geo. S. McClinton		13b. MOTHER'S MAIDEN NAME Helen Showman	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. 496-14-8612	17. INFORMANT'S SIGNATURE OR NAME Mrs. M. Trimble ADDRESS R 1 Box 77 Robertson, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lung INTERVAL BETWEEN ONSET AND DEATH 1 year ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 47d DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 162x	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION _____	
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) (Minute) _____		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 April , 19 48 , to 3-8 , 19 49 , that I last saw the deceased alive on 3-8 , 19 49 , and that death occurred at 3:00 Am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Paul T. Hartman M.D.		23b. ADDRESS 5400 Arsenal St	
23c. DATE SIGNED 3-8-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-10-1949	
24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. 3-10-49		REGISTRAR'S SIGNATURE Thurmond...	
		25. FUNERAL DIRECTOR'S SIGNATURE Alexander Bone One. ADDRESS 6175 Delmar	

Dr Paul J. Hartman
5800 Arsenal Str
before - 4 P. M.

FEB 5 1958

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 Joseph McCulloch

Signed _____
Student Embalmer

Licensed Embalmer No. 2460

P. O. Address 6175 Dilmore

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.