

FILED MAY 5 1949

THE DIVISION OF HEALTH OF THE COMMONWEALTH OF KENTUCKY
STANDARD CERTIFICATE OF DEATH

13961
State File No. 3631

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Kentucky</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bexington</u>	
c. LENGTH OF STAY (in this place) <u>5 days</u>		d. STREET ADDRESS (If rural, give location) <u>University of Kentucky</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Barnes Hospital,</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah</u> b. (Middle) <u>E.</u> c. (Last) <u>McLean</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 22, 1949</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	
8. DATE OF BIRTH <u>Oct. 24, 1895</u>		9. AGE (In years last birthday) <u>53</u>		10. IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housemother</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Univ. of Kentucky</u>		11. BIRTHPLACE (State or foreign country) <u>Lexington, Kentucky/</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>David Mc Cord</u>		13b. MOTHER'S MAIDEN NAME <u>Dora Davis</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. H. McLean Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. WM. M. Daily 5106 Westminister</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Thrombosis of left anterior inferior cerebral artery</u>		DUPLICATE OF (a) _____				
ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		DUPLICATE OF (b) <u>Hypertensive cardiovascular disease</u>				
		DUPLICATE OF (c) <u>Cerebral arteriosclerosis</u>				
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>H 22</u>		20. AUTOPSY? YES <input checked="" 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)		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 Apr. 17, 19 49, to Apr. 22, 19 49, that I last saw the deceased alive on Apr. 22, 19 49, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>FR Pradley</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Barnes Hospital</u>		23c. DATE SIGNED <u>4/22/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>4/25/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lexington Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Lexington, Kentucky</u>	

DATE REC'D BY LOCAL REG. <u>APR 22 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Kasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Suedmeyer & Son's 3934 N. 20 Street</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

nr
22
17
49

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.....

Merville B. Froelwitter

Signed.....
Student Embalmer

Licensed Embalmer No. *3696*

P. O. Address *3934 1/2 20th St*

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.