

FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17484

4757

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 MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 10 = 4377 a LEE AVE	

3. NAME OF DECEASED (Type or Print)	a. (First) MARGARET	b. (Middle) ELLEN	c. (Last) MCLAIN	4. DATE OF DEATH (Month) (Day) (Year) 5/28/49
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 12/31/1873	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 2 MINS. Mins.
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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) ST. LOUIS, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME DANIEL O'ROURKE	13b. MOTHER'S MAIDEN NAME MARY DONOVAN	14. NAME OF HUSBAND OR WIFE JAMES F. MCLAIN
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS ADELE CRAIG 4377a LEE AVE
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolism</u>		<u>15 min</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial Thrombosis</u>		<u>4-5 days</u>
	DUE TO (c) <u>Incarcerated Ventricular Aneurysm</u>		<u>10 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arteriosclerotic heart disease</u>			<u>10 yrs</u>

19a. DATE OF OPERATION 5/21/49	19b. MAJOR FINDINGS OF OPERATION <u>Incarceration of several feet small bowel</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) <u>St. Louis, Missouri</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <u>6:30</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>5/21/49</u>
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22. I hereby certify that I attended the deceased from 5/11, 1949, to 5/28, 1949, that I last saw the deceased alive on 5/28, 1949, and that death occurred at 5/28 m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>4952 Maryland</u>	23c. DATE SIGNED <u>5/31/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 6/2/49	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>MAY 31 1949</u> <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BRIDGE STROOT - CARROLL UMD CO 1600 NATURAL
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.

Student
Student Embalmer

Signed.....

J. Allen Rayne

Licensed Embalmer No. 4953

P. O. Address St. Louis

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.