

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
FILED NOV 10 1949 STANDARD CERTIFICATE OF DEATH

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3500

State File No. _____
Registrar's No. _____

BIRTH NO. 68226-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

| | | | | | |
|---|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | | c. LENGTH OF STAY (in this place) | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | | d. STREET ADDRESS (If rural, give location) <u>1602 Glasgow</u> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u> | | | d. STREET ADDRESS (If rural, give location) <u>1602 Glasgow</u> | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Report</u> b. (Middle) <u>McClelland</u> c. (Last) <u>McClelland</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>10 17 49</u> | | |
| 5. SEX <u>Fem.</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <u>10-17-49</u> | | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>2 30</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | |
| 13a. FATHER'S NAME <u>Lawrence McClelland</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Edna Mae Blackwell</u> | | 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. | 17. INFORMANT'S SIGNATURE OR NAME <u>Ethel M. Sheraid RR2601 N. Whittier</u> | | |

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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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>15th 776X</u> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 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 10-17-, 1949, to 10-17-, 1949, that I last saw the deceased alive on 10-17-, 1949 and that death occurred at 2:50p. m., from the causes and on the date stated above.

| | | | |
|--|--|--|---|
| 23a. SIGNATURE <u>William D. Smith</u> (Degree or title) <u>M. D.</u> | | 23b. ADDRESS <u>2601 N. Whittier</u> | 23c. DATE SIGNED <u>10-26-49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE <u>OCT 31 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u> | 24d. LOCATION (City, town, or county) (State) |
| DATE REC'D BY LOCAL REG. <u>OCT 31</u> | REGISTRAR'S SIGNATURE <u>J. B. Foster</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Mortuary Service Inc.</u> <u>4104 Manchester Ave. St. Louis 10, Mo.</u> | |

WRITE PLAINLY—USING UNFADING 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.

Signed _____

Signed.....

Student Embalmer

Licensed Embalmer No.

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.