

FILED FEB. 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6478

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1201**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St Louis		c. CITY OR TOWN St Louis	
c. LENGTH OF STAY (In this place) -1 day		d. STREET ADDRESS (If rural, give location) 7520 No Broadway	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hospital			

3. NAME OF DECEASED a. (First) Twda		b. (Middle) McClaren		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 2-3-1950	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 9-12-1905	
9. AGE (In years last birthday) 45		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cardwell Mo		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME James D Hicklin		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Herbert	
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 Herbert McClaren	
				ADDRESS 7520 No Broadway	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post partum shock due to hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		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) 6726	
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 **2-2**, 19**50**, to **2-3**, 19**50**, that I last saw the deceased alive on **2-2**, 19**50**, and that death occurred at **6:02 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE E.H. Bowdoin M.D.		23b. ADDRESS Mo Theatre Bldg		23c. DATE SIGNED 2-3-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-3-50		24c. NAME OF CEMETERY OR CREMATORY Cochran Cem	
				24d. LOCATION (City, town, or county) (State) Cardwell Mo	

DATE REC'D BY LOCAL REG. FEB 7 1950		REGISTRAR'S SIGNATURE J B Sauter		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	
				ADDRESS 4104 Manchester St. St. Louis 10, Mo.	

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

From interview conducted

1201

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.

Student _____
Student Embalmer

Signed Ronald O Yahrke

Licensed Embalmer No. 3917

P. O. Address OT Lewis 10 Mo

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.