

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**10483**

State File No. ....

**FILED APR 4 1955**

BIRTH NO. 72230-5-4 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 592

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Clayton</b>		c. LENGTH OF STAY (in this place) <b>1 hr</b>	c. CITY OR TOWN <b>St. Anns</b> <b>407</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Co. Hospital</b>		STREET ADDRESS (If rural, give location) <b>3452 Lindbergh</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) <b>Susan Carol McClellan</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>3 9 55</b>		
a. (First)		b. (Middle)		c. (Last)	
<b>fem</b>		<b>white</b>		<b>single</b>	
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>none</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>		<b>8. DATE OF BIRTH</b> <b>10-21-54</b>	
<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>St. Charles Missouri</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	

<b>13a. FATHER'S NAME</b> <b>James McClellan</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Margaret St. Cin</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>none</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>James McClellan, 3452 Lindbergh</b>	
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b>			

<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Acute Hemorrhagic Adrenal Necrosis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 hrs</b>	
<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUE TO (b) Bronchopneumonia, bilateral</b>		<b>Plus?</b>	
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>491X</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	

**22. I hereby certify that I attended the deceased from 3-9, 1955, to 3-9, 1955, that I last saw the deceased alive on 3-9, 1955, and that death occurred at 8:45 P.m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <i>Conrad Ray, M.D.</i>		<b>23b. ADDRESS</b> <b>601 So. Brentwood</b>		<b>23c. DATE SIGNED</b> <b>3/10/56</b>	
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24b. DATE</b> <b>3-12-55</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Mount Lebanon Cemetery</b>	
				<b>24d. LOCATION (City, town, or county) (State)</b> <b>Pattonville, Mo</b>	

<b>DATE REC'D BY LOCAL REG.</b> <b>3/10/55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Robert R. Smith</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Earl Halleman</b>	
				<b>ADDRESS</b> <b>Funeral Home Overland MO</b>	

(Licensed Embalmer's Placement on Reverse Side)

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

No. 300  
10.48  
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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.....  
Signature of Student Embalmer

Signed *E. J. Holliman*.....

Licensed Embalmer No. *3501*.....  
P. O. Address *Orland*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.