

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38750
STATE FILE NUMBER

FILED NOV 15 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2674

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Robertson		c. CITY OR TOWN Brentwood 4511	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Carters Nursing Home		d. STREET ADDRESS (If outside, give location) 8750 Rose Avenue	
Length of stay in lb 3 months		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Mollie Middle McClendon Last			4. DATE OF DEATH Month Oct. Day 26 Year 1957		
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 86.70 IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) UNKNOWN 9	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
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. unknown		17. INFORMANT Address Myra Chambers 3104 Franklin Avenue	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident - Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 20 months 30 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertension	
	DUE TO (c) 331X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour none Month none Day none Year none a. m. none p. m. none					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) none		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from 2-2-56 to 10-26-57 and last saw her alive on 10-26-57 Death occurred at 9:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Francis J. Alkinder			22b. ADDRESS 826 N Channing Ave		22c. DATE SIGNED 10-28-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/57	23c. NAME OF CEMETERY OR CREMATORY Father Dickson		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR ADDRESS Peoples Und.Co. 3100 Franklin Ave			25. DATE RECD. BY LOCAL REG. 10/29/57	26. REGISTRAR'S SIGNATURE Berbert S. Donald MD <i>arc</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300-1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Arthur P. Herd*

Licensed Embalmer No. *422*
P. O. Address *3100 East*

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.