

pt. Health,
e. & Welfare
S. Public
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XC-1225 806

THE DIVISION OF HEALTH OF MISSOURI

42300

SL 14851 FILED DEC 13 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
11781

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11781

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		c. CITY OR TOWN PACIFIC	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) 3/	
3. NAME OF DECEASED (Type or print) First JAMES Middle P. Last MC LAREN		4. DATE OF DEATH Month DECEMBER Day 7, Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONARY FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) GRANITEVILLE, MO.
13a. FATHER'S NAME JAMES E. MC LAREN		13b. MOTHER'S MAIDEN NAME SONORA BEAVE	14. NAME OF HUSBAND OR WIFE MINNIE MC LAREN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 498-18-6296	17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMPHYSEMA, OBSTRUCTIVE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PULMONARY TBC, ACTIVE DUE TO (c) 002x			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN
20a. ACCIDENT - SUICIDE - HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 9/20/57 to 12/7/57 and last saw him alive on 12/7/57 Death occurred at 7:40 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thomas L. Wright MD.		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 12/7/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/10/57	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cem.	23d. LOCATION (City, town, or county) (State) Pacific Mo.
24. FUNERAL DIRECTOR Mrs. John L. Thibet Pacific		25. DATE RECD. BY LOCAL REG. DEC 9 57	26. REGISTRAR'S SIGNATURE Carl Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

DEC 13 1957

MAY 28 1958

DEC 30 1957

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 *Ralph Altman*

Licensed Embalmer No. *4808*
P. O. Address *Union, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.