

XC-907 712
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3249
STATE FILE NUMBER
1128
Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY ST. CLAIR	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN E. ST. LOUIS 812 th	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL		d. STREET ADDRESS (If outside, give location) 322 NATALIE	
3. NAME OF DECEASED (Type or print) First Middle Last EARL MC CLAIN		4. DATE OF DEATH Month Day Year 1-29-58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRAINMAN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) TENNESSEE
13a. FATHER'S NAME JOHN MC CLAIN		13b. MOTHER'S MAIDEN NAME MARY WARFIELD	14. NAME OF HUSBAND OR WIFE DECEASED
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW - I		16. SOCIAL SECURITY NO. 335-01-1526	17. INFORMANT Address VA HOSP RECORDS 915 N GRAND 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) ACUTE PERITONITIS			INTERVAL BETWEEN ONSET AND DEATH 1 DAY
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) MESENTERIC THROMBOSIS OF ARTERIES OF COLON			5 DAY
DUE TO (c) ARTERIOSCLEROSIS			-
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CARCINOMA OF ESOPHAGUS			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> none <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 1-6-58 to 1-29-58 and last saw him alive on 1-29-58 Death occurred at 10:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>[Signature]</i>		22b. ADDRESS M. D. VAH. ST. LOUIS, MO.	22c. DATE SIGNED 1-30-58
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal		23b. CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR ADDRESS John J. Kassly, E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. JAN 30 '58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i> S.P.

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.

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 Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed John J. Cassidy.....

Licensed Embalmer No. 6855.....
P. O. Address St. James, Ill.....

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) **EMERALD**
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.