

FILED MAY 1 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016120

STATE FILE NUMBER

318

1003

4414

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2740 Chippewa</b>		Length of stay in 1b <b>24</b>	d. STREET ADDRESS (If outside, give location) <b>2740 Chippewa</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>BLANCHE</b>		First <b>Mc CLELLAN</b>	4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-9-1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR <b>House Work</b>	9. AGE (In years birthday) <b>72</b> FUNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>John Larreiau</b>		13b. MOTHER'S MAIDEN NAME <b>Veronica Roberts</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT, Address <b>Blennard Brinkman 3443A Dunnica</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastroenteritis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Chronic cholecystitis</b> DUE TO (c) <b>585x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <b>May 1943</b> , to <b>April 22</b> and last saw her alive on <b>April 22 1958</b> Death occurred at <b>4:30 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>D J Johnson M.D.</b>		22b. ADDRESS <b>6400 Morganford</b>	22c. DATE SIGNED <b>4-22-58</b>
23a. BURIAL, CREMATION, REMOVAL <b>Removal</b>		23b. DATE <b>4-24-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. Olive Cem.</b>
23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>WINGBERMUEBLE 3819 S Grand Blvd</b>		25. DATE RECD. BY LOCAL REG. <b>APR 23 '58</b>	26. REGISTRAR'S SIGNATURE <b>J Carl Smith MD</b> <b>mdb.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ..... Student Embalmer No. .... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed *George D. Angles* ..... Licensed Embalmer No. *4611*

P. O. Address *St. Louis 18 2*

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.