

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015356

STATE FILE NUMBER

FILED MAY 6 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. **3909**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP # 1		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 1038 Marion Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SARAH FRANCES McCLAREN			4. DATE OF DEATH Month Day Year APRIL 17, 1959
5. SEX Female	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 11-25-1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Keyesport, Ill.
13a. FATHER'S NAME Andrew Bruner		13b. MOTHER'S MAIDEN NAME Alice Norman	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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.	17. INFORMANT Address Richard McClaren, 1038 Marion
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0			INTERVAL BETWEEN ONSET AND DEATH
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 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 <u>4/4/59</u> to <u>4/17/59</u> and last saw her alive on <u>4/17/59</u> Death occurred at <u>5:45 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph Michael M.D.</u>		22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 4/17/59
23a. BURIAL (CREMATION, REMOVAL) (Specify) Removal	23b. DATE 4-20-1959	23c. NAME OF CEMETERY OR CREMATORY Memorila Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette Ave.		25. DATE RECD. BY LOCAL REG. APR 20 '59	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u> md 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

James R. Chapman
Licensed Embalmer No. *4555*
P. O. Address *At Law*

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.