RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 14 1960

-60-008571

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2159

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Mo. Baptist Hosp.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN: Webster Groves
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 351 Gray Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: ERNEST Middle: G. Last: McLAGAN
4. DATE OF DEATH: Month Feb. Day 23, Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1-2-88
9. AGE (last birthday): 72
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Allis-Chalmers
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: John McLagan
13b. MOTHER'S MAIDEN NAME: Martha Alice Green
14. NAME OF HUSBAND OR WIFE: Adelaide McLagan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 489-05-7188
17. INFORMANT: Mrs. E. G. McLagan, 351 Gray Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic Heart disease with fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 2-12-54, to 2-23-60 and last saw him alive on 2-23-60
Death occurred at 10 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Norman Bailey MD
22b. ADDRESS: Mo Theatre Bldg 819 Olive St.
22c. DATE SIGNED: 2-24-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: 2-26-60
23c. NAME OF CEMETERY OR CREMATORY: Vahalla Crematory
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR: Parker-Aldrich, Webster Groves ADDRESS
25. DATE RECD. BY LOCAL REG.: FEB 24 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. MB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Leslie Welch

Signature of Student Embalmer

Licensed Embalmer No. 439

P. O. Address Webster

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.