

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		Length of stay in lb 40 YRS.	c. CITY OR TOWN St. Louis Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 116 Elwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 116 Elwood
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Carrie Middle Mae Last McClaren			4. DATE OF DEATH Month 9 Day 10 Year 1960		
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-18-1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Ballard County Ky.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John Davis		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Arthur McClaren	
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. 499-34-5698	17. INFORMANT Arthur McClaren Address 116 Elwood		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure			INTERVAL BETWEEN ONSET AND DEATH 6 yrs
DUE TO (b) arterio sclerotic CVA Disease			
DUE TO (c) 442x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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. Month, Day, Year		

20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from **4-19-60** to **9-10-60** and last saw her/him alive on **9-2-60**
 Death occurred at **12 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. A. Rester M.D. (Degree or title)	22b. ADDRESS 5600 S Compton	22c. DATE SIGNED 9-13-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-14-1960	23c. NAME OF CEMETERY OR CREMATORY St. Mathews Cemetery
23d. LOCATION (City, town, or county) St. Louis, Missouri		(State)

24. FUNERAL DIRECTOR McLaughlin ADDRESS 2301 Lafayette Ave	25. DATE RECD. BY LOCAL REG. SEP 13 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

DR. NESTER
5600 S SCRIPTON
12-4 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed A. G. Farris

Licensed Embalmer No. 338

P. O. Address St. Louis

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