

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023520  
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1659

FILED JUN 21 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood</b>		Length of stay in 1b <b>23 yrs.</b>	c. CITY OR TOWN <b>Kirkwood</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>612 Nirk Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>612 Nirk Ave.</b>
3. NAME OF DECEASED (Type or print) First <b>EDWIN</b> Middle <b>LEE</b> Last <b>MC CLELLAND</b>		4. DATE OF DEATH <b>June 13, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-7-1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woodbine Mkt.</b>	9. AGE (last birthday) <b>75</b>
11a. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Robert Mc Clelland</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Louise Dettermann</b>	
14. NAME OF HUSBAND OR WIFE <b>Caroline I. McCLELLAND</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>612 Nirk-Kirkwood, Mo Caroline I. Mc Clelland</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>Unknown Natural Causes</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____			
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 _____
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
23a. SIGNATURE (Degree or title) <b>John C. Murphy MD Asst. Health Commissioner</b>		22b. ADDRESS <b>801 S. Brentwood Clayton Mo.</b>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6-19-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Kirkwood 22 Mo.</b>
24. FUNERAL DIRECTOR <b>Pfitzinger Mort-Kirkwood 22, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-14-61</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>

**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 *Gene Hoffman*

Licensed Embalmer No. 4366

P. O. Address *Spencer*

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.