

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003800

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 940 STATE FILE NUMBER

FILED FEB 8 1963

DO NOT WRITE ON THIS STUB AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
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USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>24 YRS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2644 Hickory</u>		d. STREET ADDRESS (If outside, give location) <u>2644 HICKORY</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENNIE LEE MCCLAIN</u>			4. DATE OF DEATH Month Day Year <u>JAN. 26 1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-1912</u>
9. AGE (last birthday) <u>50 YRS.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MOUNT BAYOU MISS</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>ED. MCCLAIN</u>	
13b. MOTHER'S MAIDEN NAME <u>SALLIE LEGGS</u>		14. NAME OF HUSBAND OR WIFE <u>ALICE MCCLAIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>OSCAR MCCLAIN 1841 CASS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of the Anterior descending branch of the left coronary artery.</u> DUE TO (b) <u>4201</u> DUE TO (c) <u>4201</u> 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 checked="" type="checkbox"/> NO <input 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 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 alive on _____ Death occurred at <u>12-11-A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Helen L. Taylor, Coroner</u>		22b. ADDRESS <u>1300 Clark Ave.</u>	22c. DATE SIGNED <u>1-29-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-31-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAKDALE CEMETERY LEMAY</u>	23d. LOCATION (City, town, or county) (State) <u>Mo.</u>
24. FUNERAL DIRECTOR <u>McC/12/17</u>		ADDRESS <u>1841 CASS</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 29 1963</u>
26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>			

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 Wallace R. Williams

Licensed Embalmer No. 4926

P. O. Address 5135 Federal

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.