

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....
Towship.....
City St. Louis Mo (No. 791)

Registration District No. 791
Primary Registration District No. 1303
St. Johns Hosp

File No. 29044
Registered No. 8550
St. _____ Ward)

2. FULL NAME

Hanna Louise McClanahan
(a) Residence. No. St. Francis Mo, 1st Ward. St. Francis Mo
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. A. McClanahan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 11 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 8 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Washington Co. Mo

10. NAME OF FATHER William Cain

11. BIRTHPLACE OF FATHER (CITY OR TOWN, STATE OR COUNTRY) St. Charles Mo

12. MAIDEN NAME OF MOTHER Hanna Schegg

13. BIRTHPLACE OF MOTHER (CITY OR TOWN, STATE OR COUNTRY) Union Mo

14. INFORMANT (Address) J. A. McClanahan St. Francis Mo

15. FILED 23 1928 Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 21 1928

17. I HEREBY CERTIFY That I attended deceased from Aug 20, 1928, to Aug 21, 1928 that I last saw her alive on Aug 21, 1928, and that death occurred, on the date stated above, at 5 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
12-8 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) none
117B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

1 DID AN OPERATION PRECEDE DEATH? DATE OF 8/20/28

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chloroform

(Signed) J. A. McClanahan, M.D.

(Address) St. Francis Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REGIONAL St. Francis Mo DATE OF BURIAL 8-24 1928

20. UNDERTAKER Boyer Und. Co. ADDRESS St. Louis Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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