URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-042796
STATE FILE NUMBER

AENDED

FILED VS DEC 3 1959

Registration District No. 5317 Primary Registration District No. 541 Registrar's No. 2916

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON
Length of stay in 1b HRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST LOUIS COUNTY
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI COUNTY ST LOUIS
c. CITY OR TOWN 240 ST MAURICE
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) FLORRISANT MO
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Bertha Middle Last McClanahan

4. DATE OF DEATH Month 12 Day 2 Year 59

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 8-11-85

9. AGE (last birthday) 93

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) HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY HOME

11. BIRTHPLACE (City and state or country) ST FRANCOIS CTY

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JACOB LARBY

13b. MOTHER'S MAIDEN NAME CORDELIA BURGESS

14. NAME OF HUSBAND OR WIFE GEO W McCLANAHAN

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. NO

17. INFORMANT LEE McCLANAHAN Address 4834 REAVIS

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) Pulmonary edema, bilateral
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 2 DAYS

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 12-2-59, to 12-2-59 and last saw her/him alive on 12-2-59
Death occurred at 10:35 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Marshall June MD

22b. ADDRESS 601 So. Brentwood, Clayton Mo.

22c. DATE SIGNED 12/3/59

23a. BURIAL (Burial, Cremation, Removal) BURIAL

23b. DATE 12-6-59

23c. NAME OF CEMETERY OR CREMATORY PARKVIEW

23d. LOCATION (City, town, or county) (State) NEAR FARMINGTON MO

24. FUNERAL DIRECTOR A Cozean

ADDRESS 217 W COLUMBIA FARMINGTON MO

25. DATE RECD. BY LOCAL REG. 12-3-59

26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

DOCUMENT

DEC 18 1959

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 C A Cozean

Licensed Embalmer No. 4084

P. O. Address Farmington N

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