

REC'D JUN 12 1939

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

16540  
Do not use this space.

791  
1003

Registered No. 4074

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. ....  
(c) City or Town ..... Saint Louis ..... (d) Street No. .... Homer G. Phillips Hosp. .... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 43 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME <sup>341</sup> Matthew McClure

(a) Residence, No. No Home St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth McClure

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13th, 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
56 9 15

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer  
9. Industry or business in which work was done, as saw mill, bank, etc. Foundry  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) Rocheport (STATE OR COUNTRY) Missouri

FATHER 13. NAME Alec McClure

14. BIRTHPLACE (CITY OR TOWN) Rocheport (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Katie Pipes

16. BIRTHPLACE (CITY OR TOWN) Rocheport (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Bessie M. Coleman 4204 W. Page Blvd.

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE 5/3/39

19. FUNERAL DIRECTOR (NAME) Charles J. Gates (ADDRESS) 4107-09 Finney Avenue

20. FILED MAY 2 1939 J. B. [Signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28th, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 26, 1939, to April 28th, 1939

I last saw him alive on April 28th, 1939 Death is said to have occurred on the date stated above, at 4 p.m.  
The principal cause of death and related causes of importance were as follows:

Cerebral thrombosis Date of onset 4/26/39

Other contributory causes of importance:

Name of operation ..... Date of .....  
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify .....  
(Signed) Herbert [Signature] M. D.  
(Address) Homer G. Phillips Hosp. ....

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

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.

STATEMENT BY LICENSED EMBALMER

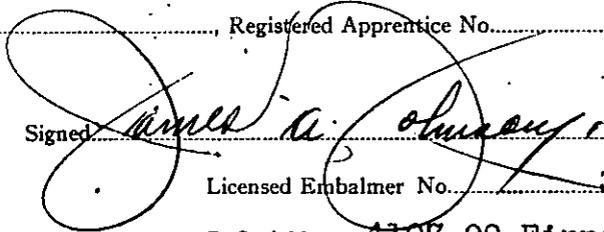
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No. 3522

P. O. Address 4107-09 Finney Ave.

**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 this body is not embalmed, above space should be left blank.