No. 300
10-48

FILED JUN 29 1951

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

21319

State File No. .....

BIRTH NO. ..... REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5585

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH**
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Miss ouri Baptist Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2129

d. STREET ADDRESS (If rural, give location): 308 N. Clara

**3. NAME OF DECEASED** (Type or Print)
a. (First): Ida
b. (Middle): Belle
c. (Last): McClanahan

**4. DATE OF DEATH** (Month) (Day) (Year): June 20, 1951

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Widow
**8. DATE OF BIRTH**: Sept. 21, 1867
**9. AGE** (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housework
**10b. KIND OF BUSINESS OR INDUSTRY**: At Home
**11. BIRTHPLACE** (State or foreign country): Robison Co., Tenn.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13a. FATHER'S NAME**: Thomas Stringer
**13b. MOTHER'S MAIDEN NAME**: Unknown
**14. NAME OF HUSBAND OR WIFE**: W.S. 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.**: None
**17. INFORMANT'S SIGNATURE OR NAME** ADDRESS: David E. Clark, 308 N. Clara Ave.

**18. CAUSE OF DEATH**
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion (Thrombosis) — INTERVAL BETWEEN ONSET AND DEATH: immed.

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Coronary sclerosis — 10 yrs +
DUE TO (c) Arteriosclerotic heart disease — 10 yrs +

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**
**20. AUTOPSY?** YES ☐ NO ☒

**21a. ACCIDENT SUICIDE HOMICIDE** (Specify)
**21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.)
**21c. (CITY, TOWN, OR TOWNSHIP)** (COUNTY) (STATE)

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?** 4300

22. *I hereby certify that I attended the deceased from* 6-10-51, 19___, *to* 6-19-51, 19___, *that I last saw the deceased alive on* 6-19-51, 19___, *and that death occurred at* 12:15a *m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): John L. Kennedy MD. CM.
**23b. ADDRESS**: 508 no Grand
**23c. DATE SIGNED**: 6-20-51

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal
**24b. DATE**: 6-20-51
**24c. NAME OF CEMETERY OR CREMATORY**
**24d. LOCATION** (City, town, or county) (State): Franklin, Ky.

DATE REC'D BY LOCAL REG.: JUN 20 1951
REGISTRAR'S SIGNATURE: J B Lasater
**25. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

## 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 me

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed [illegible]

Licensed Embalmer No. [illegible]

P. O. Address [illegible]

**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, fact should be so stated above.