

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003823

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District 1003 Registrar's No. 33

FILED JAN 16 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <u>208</u>				
3				
4 <u>1</u>				
5 <u>1</u>				
6				
7 <u>1</u>				
8 <u>1</u>				
9				
10				
11				
12 <u>58-0</u>	MEDICAL CERTIFICATION	BY AFFIDAVIT OF		
13				
58	SHOULD READ	BY AFFIDAVIT OF		

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> 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>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>7849 Hall St.,</u>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>E.</u> Last <u>MC LEAN</u>		4. DATE OF DEATH Month <u>Januray</u> Day <u>1st</u> Year <u>1963</u>	
5. SEX <u>female</u>	6. COLOR OR RACE. <u>white</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>3/24/11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bird Island, Minn</u>
13a. FATHER'S NAME <u>Paul Kolbe</u>		13b. MOTHER'S MAIDEN NAME <u>---</u>	14. NAME OF HUSBAND OR WIFE <u>Walter McLean</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>no</u>		16. SOCIAL SECURITY NO. <u>7</u>	17. INFORMANT Address <u>Walter McLean, 7849 Hall St.,</u>
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breasts Generalized metastases</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c): <u>170X</u>			
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 checked="" 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.	Month, Day, Year		
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 <u>June 1947</u> to <u>1-Jan-63</u> and last saw her alive on <u>31-Dec 62</u> Death occurred at <u>6:50 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Helen McLean</u>		(Degree or title)	22b. ADDRESS <u>4501 Manchester</u>
22c. DATE SIGNED <u>7-Jan-63</u>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1/4/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>DIEDRICH FUNERAL HOME, 8319 Hallsferry</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 3 1963</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 *J. M. [Signature]*

Licensed Embalmer No. 3653

P. O. Address *[Signature]*

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.