

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL STATISTICS

CERTIFICATE OF DEATH

Dist. 060Serial No. 1046State File No. 11361

1. NAME OF DECEASED (Type or Print)			a. (First) <u>Lawrence</u>	b. (Middle) <u>L.</u>	c. (Last) <u>McClure</u>	2. DATE OF DEATH (Month) (Day) (Year) <u>September 1st, 1949</u>			
3. PLACE OF DEATH a. County <u>Cabell</u>					4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. State <u>West Virginia</u> b. County <u>Cabell</u>				
b. City (If outside corporate limits, write RURAL and give Dist.) or Town <u>Huntington</u>					c. Length of Stay (in this place)				
d. Full Name of (If not in hospital or institution, give street address or location.) Hospital or Institution <u>St. Marys Hospital</u>					d. Street Address (If rural, give location) <u>1223- Eighth Avenue</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, SINGLE, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 8th, 1884</u>		9. AGE (In years) IF UNDER 1 YEAR Months Days Hours Min. <u>64 10 23 </u>	
10a. USUAL OCCUPATION <u>Attorney</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>7</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>			17. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Taylor McClurs</u>					14. MOTHER'S MAIDEN NAME <u>Alice Burgess</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT				
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, asthma, etc. It means the disease, injury or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>(a) Cirrhosis, hepatic</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Due to (b) Due to (c) <u>5810-124B</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION							
21a. ACCIDENT SUICIDE HOMICIDE (Specify)			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. CITY OR DISTRICT (COUNTY) (STATE)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY			21e. INJURY OCCURRED While at <input type="checkbox"/> Not while at Work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?			
21g. INQUEST Yes <input type="checkbox"/> No <input type="checkbox"/>			22. I hereby certify that I attended the deceased <u>Aug. 29</u> , 19 <u>49</u> , to <u>Sept. 1</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Sept. 1</u> , 19 <u>49</u> , and that death occurred at <u>11</u> a.m., from the cause and on the date stated above.						
23a. SIGNATURE <u>Walter E. Vest, M.D.</u>			23b. ADDRESS <u>955 Fourth Ave.</u>			23c. DATE SIGNED <u>9/26/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Sept. 2nd, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Woodmere</u>		24d. EMBALMERS SIGNATURE <u>V.P. Lawton</u>		LIC. NO. <u>1072</u>	
DATE REC'D BY LOCAL REG. <u>9-26-49</u>			REGISTRAR'S SIGNATURE <u>W. S. Carpenter</u>			25. FUNERAL DIRECTORS SIGNATURE <u>V.S. Carpenter</u>			LIC. NO. <u>1171</u>

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.