

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

Do not use this space.

28518

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City..... (No. Baptist Hosp) St. .... Ward)

File No. ....  
 Registered No. 8048

**2. FULL NAME**

Male Infant of C. F. W. Jessie Clausen  
 (a) Residence. No. H 718 Arsenal St. 16 Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>9-7-27</u>		
7. AGE YEARS _____	MONTHS _____	DAYS <u>3</u> If LESS than 1 day, _____ hr. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9. BIRTHPLACE (CITY OR TOWN) St. Louis  
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER C. F. W. Clausen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Wisconsin

12. MAIDEN NAME OF MOTHER Jessie Ellis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Mo.

14. INFORMANT C. F. W. Clausen  
 (Address) 308 So 4th St

15. FILED SEP 10 1927  
Wm C. Starnes  
 REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep - 10 1927  
 17. I HEREBY CERTIFY, That I attended deceased from Sep - 7 1927, to Sep 10 1927, that I last saw him alive on Sep 10 1927, and that death occurred, on the date stated above, 12 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Convulsions due to  
Intra-cranial Pressure  
160B  
157 (duration) yrs. mos. 1 da.  
 CONTRIBUTORY Prevention Berk  
 (SECONDARY) 8 mo. gestation  
 (duration) yrs. mos. 3 da.

18. WHERE WAS DISEASE CONTRACTED  
Blain Bay Hosp.  
 IF NOT AT PLACE OF DEATH  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? Cerebral  
 (Signed) R. E. Dwyer M. D.  
9/10/27 (Address) University Club Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla DATE OF BURIAL 9/10 1927  
 20. UNDERTAKER Wayover Undertaker ADDRESS 3621 Pleasant

WRITE PAINLY, WITH UNFADING INK---THIS IS 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.

