

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

Do not use this space.

17650

1. PLACE OF DEATH

County..... Registration District No. 1 791
Township..... Primary Registration District No. 1003
City St. Louis Mo. (No. 1711) Carroll St. St. Ward)

File No.
Registered No. 4737
St. Ward)

2. FULL NAME

James Henry Clem

(a) Residence No. 1711 Carroll St. 23 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

Male White Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or ~~WIDOWED~~)

Viola Dell Clem

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 2 1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
43 1 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) Genl. Maintenance
(c) Name of employer J.C. Penny & Co.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER James R. Clem

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Viola Dell Clem
(Address) 1711 Carroll

15. FILED May 11 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 11, 1930

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from

19..... to..... 19....., and that that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... 5:40 a..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asphyxiation due to hanging by strap
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 165 Hg. Suicidal
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John M. D.

5/12, 19 30 (Address) St. Louis, Mo.

*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 DATE OF BURIAL

Memorial Park Cemetery 5-14-1930

20. UNDERTAKER ADDRESS

M^{rs} Laughlin 1631 Madison

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.

