

REC'D JUN 12 1939 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

17296
Do not use this space.

1. PLACE OF DEATH Enroute Homer Phillips Hospital
 (a) County.....3 Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No..... 4830
 (c) City St. Louis (d) Street No. En Route City Hosp #2 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Thomas Clark
 (a) Residence, No. 2809 R. Dayton St. 21 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ella Clark

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) UNKNOWN

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
About 68 - - -

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Plummer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisiana

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Ella Clark
2014 Division St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Father Dickson DATE 5-27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. L. Garner
2829 Washington Ave.

20. FILED MAY 27 1939
J. D. Baedeker Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/17/39 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at 6:00 P.M. in _____.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Arterio Sclerosis

Other contributory causes of importance: None

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19____
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify Alfred Perry
 (Signed) Alfred Perry (Address) Alfred Perry

WRITE PLAINLY, WITH UNFADING INK---THIS IS A 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.

I X 16605

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Arthur L. Hilliard*

Licensed Embalmer No. *3389*

P. O. Address *3028 Dickens*

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, above space should be left blank.