

1 X1931
MAKE PERMANENT COPY UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

SEP 14 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27414

State File No.

6914

Registrar's No.

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

1003

2

- (a) County _____
- (b) City or town St. Louis
- (c) Name of hospital or institution: 3437 Virginia Ave.
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution _____
(Specify whether _____)

3. (a) PRINT FULL NAME Hattie Clark 462

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Clark 6. (c) Age of husband or wife if alive 86 years

7. Birth date of deceased March 8, 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>4</u>	<u>29</u>	hr. _____ min. _____

9. Birthplace Wisconsin
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Mathews Brooks /

18. Birthplace New York
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Albertia ?
15. Birthplace Wisconsin
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Otto J. Zukerman
(b) Address 3437 Virginia Ave.

17. (a) Burial (b) Date thereof Aug. 9/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cem.

18. (a) Signature of funeral director Jas. W. Weirh.
(b) Address 1125 Hodiamont Ave.

19. (a) AUG 8 1939 (b) J. B. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County 1
- (c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")
- (d) Street No. 3437 Virginia Ave.
(If rural, give location)
- (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 6
year 1939 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from 6. 15. 1936 to 8. 6. 1939
that I last saw h. er alive on 8. 6. 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 5 da.

Due to Old hemiplegia caused 3 yrs.

Due to by cerebral hemorrhage 3 yrs.

Ch. Myocarditis

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
- (b) Date of occurrence _____
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Eugene Al Opel (M. D. or other) 8/6/39
Address 3325 S. Grand Date signed _____

D^r. E.A. Vogel,
3325 So/Grand Blvd.,
Pr. 0549.

2-4 PM.

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.....

Jos. W. Clark

Licensed Embalmer No..... I66I.....

P. O. Address. 1125 Hodiament Ave......

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.