

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-30
 Form 1 X 19311

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.

Registration District No. 791 Primary Registration District No. 10036

1. PLACE OF DEATH:
 (a) County St. Louis Mo!
 (b) City or town St. Louis Mo!
 (c) Name of hospital or institution: Christie Hospital
 (If not in hospital or institution, write street number of location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days
 3. (a) PRINT FULL NAME Baby Clark 467
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov 23 1939
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
Still Born

9. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 { 12. Name Marjorie Clark
 { 13. Birthplace St. Louis Mo.
 { 14. Maiden name Josephine Clark
 { 15. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marjorie Clark
 (b) Address 4205 E. Maffitt Ave.

17. (a) _____ (b) Date thereof Nov 24 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Catholic cemetery

18. (a) Signature of funeral director John J. ...
 (b) Address 4217 St. Louis Ave.

19. (a) NOV 24 1939
 (Date received local registrar) (b) Signature J. Brubaker
 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County 1
 (c) City or town St. Louis 11
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4205 E. Maffitt Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov day 23, 1939
 year _____ hour 9 minute 20 A. M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death stillborn Duration _____
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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 H. ... (M. D. or other) _____
 Address 5074 N. Union Date signed 11-24-39

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 Edw. J. Howard

Licensed Embalmer No. 1443

P. O. Address.....

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.