

No. 2
11-10-39
1-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

364220 ✓

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 784

Primary Registration District No. 115

Registrar's No. 1948

1. PLACE OF DEATH:

(a) County SAINT LOUIS:
(b) City or town UNIVERSITY CITY:
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
#1517 BRADFORD AVE:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI: (b) County SAINT LOUIS:
(c) City or town UNIVERSITY CITY:
(If outside city or town limits, write "RURAL")
(d) Street No. 1517 BRADFORD AVE:
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME ANNA KUNZE CLARK

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife ALFRED SHERIDAN CLARK 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased MARCH 16 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 6 26 hr. _____ min.

9. Birthplace ST. CLAIR COUNTY ILLINOIS
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME:

11. Industry or business _____

MOTHER FATHER
12. Name JULIUS KUNZE
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name LEHMANN
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant ROY R. CLARK
(b) Address 1517 BRADFORD AVE:

17. (a) BURIAL (b) Date thereof 10/15/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CEMETERY

18. (a) Signature of funeral director C. R. LUPTON SONS
(b) Address # 7233 DELMAR BLVD:

19. (a) OCT 15 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12
year 1940 hour 8 minute A M.

21. I hereby certify that I attended the deceased from Nov
1939, to Oct 1940
that I last saw her alive on Oct 11 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
chronic with decompensation
Duration 1 year

Due to Hypertensive
vascular disease &
arteriosclerosis.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93C
Of autopsy _____

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 [Signature] (M. D. or other) M.D.
Address 500 Olive Date signed 10/13/40

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

506 Olive
CH. 5025

11-3 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 _____

Don Muschany

Registered Apprentice No. 219

working under my personal supervision.

Signed *Bradford A. Miles*

Licensed Embalmer No. 2901

P. O. Address St Louis Mo

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.