

RECEIVED SEP 17 1941
 MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26528

6320

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
 (b) *City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) *Name of hospital or institution:
Mohn Nurseing Home 5861 Cates Ave.,
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 year 4 months
 (Specify whether
 In this community 1 year 4 months
 years, months or days)

3. (a) PRINT FULL NAME Clara Pauline Giddings3. (b) If veteran, name war. No 3. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife. John P. 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased. February 4 1868
 (Month) (Day) (Year)8. AGE: Years Months Days If less than one day
73 5 29 hr. min.9. Birthplace Sandy Lake Penna.
 (City, town, or county) (State or foreign country)10. Usual occupation Retired11. Industry or business Housewife12. Name Henry Osthimer13. Birthplace Holland
 (City, town, or county) (State or foreign country)14. Maiden name Josephine Glenn
 15. Birthplace Sandy Lake Penna.
 (City, town, or county) (State or foreign country)16. (a) Informant's own signature Paul Giddings(b) Address 620 S. Lafayette Macomb, Ill17. (a) Burial (b) Date thereof Aug 4 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Corfu, New York18. (a) Signature of funeral director Jos. W. Clark(b) Address 1125 Hediamont Ave.19. (a) AUG - 1 1941 (b) J. H. Fredrick
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County Genesee
 (c) City or town Corfu
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
 year 1941 hour 2 45 PM minute _____ M.21. I hereby certify that I attended the deceased from Jan 1, 1930
 _____, 19 _____, to July 31, 1941, 19 _____;
 that I last saw her alive on July 31, 1941, 19 _____;
 and that death occurred on the date and hour stated above.Immediate cause of death chain myocarditis Duration _____
 Due to _____
 Due to _____Other conditions None
 (Include pregnancy within 3 months of death)Major findings: None PHYSICIAN _____
 Of operations _____Of autopsy _____
 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 Will O. West (M. D. or other) M.D.
 Address 1178 Hudsonian Date signed 8-1-41

Dr. O.O. White
Hodiamont & Etzel Aves.,
9.00A&.M.

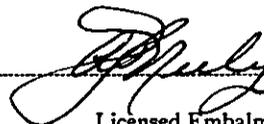
STATEMENT BY LICENSED EMBALMER

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



Licensed Embalmer No. 3225

P. O. Address 1125 Hodiamont 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.