

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 239

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 yr 1 mo 25 days  
(Specify whether  
In this community life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4157 Kennerly  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME ARYELLE M CLAYBORNE

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

20. DATE OF DEATH: Month Jan day 29  
year 1942 hour 12 minute 00 noon

21. I hereby certify that I attended the deceased from Dec 4, 1940, to Jan 29, 1942  
that I last saw him alive on Jan 29, 1942  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro  
6. (a) Single, widowed, married, divorced married  
(b) Name of husband or wife Robert Clayborne  
6. (c) Age of husband or wife if alive, years 27 1903  
7. Birth date of deceased July (Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis Duration ?

8. AGE: Years 38 Months 6 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to IBK  
Due to \_\_\_\_\_

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

Other conditions Tuberculosis of Spine ?  
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Thomas Hunt  
13. Birthplace Tenn (City, town, or county) (State or foreign country)  
14. Maiden name Sally ?  
15. Birthplace Tenn (City, town, or county) (State or foreign country)

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

16. (a) Informant Hospital Record  
(b) Address Robert Koch Hospital  
17. (a) BURIAL (b) Date thereof 2-2-42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park  
18. (a) Signature of funeral director Bennie Love  
(b) Address 3103 Washburn St  
19. (a) JAN 31 1942 (b) C. J. McNamee  
(Date received local registrar) (Registrar's signature)

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 0  
23. Signature Frank Cohen (M. D. or other) MD  
Address Robert Koch Hosp. Date signed 1/30/42

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

FEB 16 1942

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.....

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

Signed *William Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *2649 Delmar Bl*

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, fact should be so stated above.