

FILED JAN 3 1944

Registration District No. 7

Primary Registration District No. 6076

Registrar's No. 2883

1. PLACE OF DEATH:

(a) County: ST. LOUIS
(b) City or town: BALLWIN MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
PINE CREST NURSING HOME 4
(If not in hospital or institution, give street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community: 3 yr 4 mo 6 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: ST. LOUIS
(c) City or town: BALLWIN
(If outside city or town limits, write "RURAL")
(d) Street No.: PINE CREST NURSING HOME
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: ROBERT C. CLAYBORNE

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

4. Sex: Male 5. Color or race: White 6. (a) Single, widowed, married, divorced: Widower

6. (b) Name of husband or wife: Alice Clayborne 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: June 22 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
-85 5 27 hr. min.

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

10. Usual occupation: Unemployed

11. Industry or business _____

MOTHER FATHER

12. Name: Robert Clayborne

13. Birthplace: Unknown Virginia
(City, town, or county) (State or foreign country)

14. Maiden name: Ann Porter

15. Birthplace: Unknown Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Kate Dace
(b) Address: 3505 Iowa Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-22-43
(Month) (Day) (Year)

(c) Place: burial or cremation: Bonne Terre, Mo.

18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.

19. (a) DEC 24 1943 (b) E. S. Mc Linn, M.D.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 19
year: 1943 hour: 9 minute: 12 A M.
21. I hereby certify that I attended the deceased from Aug 13 1941 to Aug 13 1943

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

Immediate cause of death: Chronic Myocarditis Duration _____

Due to _____

Due to _____

Other conditions: Bronchial Asthma
(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: R. H. Jansen (M. D. or _____)
Address: Manchester, Mo. Date signed: _____

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

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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 *Albert G. Hoffe*.....

Licensed Embalmer No. *2971*.....

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, fact should be so stated above.