

V. S. No. 2
FORM-8-43
Rev. 5-17-39
I X37223

31703

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2050

FILED OCT 13 1944
Registration District No. 3063

Primary Registration District No. 3063

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 35 days
In this community 12 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town University City,
(If outside city or town limits, write "RURAL")
(d) Street No. 6610 Bartmer Ave.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN CLOVER
3. (b) If veteran, name war No
3. (c) Social Security No. 493-09-5488

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 7th
year 1944 hour 11 minute 35 a.m.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Martha Riley
6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased Dec. 5 1909
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 3 1944 to Oct. 7 1944
that I last saw him alive on Oct. 7 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 34 Months 9 Days 2
If less than one day _____ hr. _____ min.

Immediate cause of death Subarachnoid basal meningitis
Due to C.A.S. Les
Due to 308

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

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

10. Usual occupation Welder

11. Industry or business _____
12. Name Jess Clover Sr.
13. Birthplace Glen Elder Kans.
(City, town, or county) (State or foreign country)
14. Maiden name Maude Young
15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

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 _____

16. (a) Informant Martha Clover - wife
(b) Address 6610 Bartmer Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11/44.
(Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.

23. Signature H. Meyer M.D. (M. D. or other) _____
Address Cambry Corp. Date signed 10-7-44

19. (a) OCT 9 1944 (Date received local registrar)
(b) E. G. Mullerau M.D. (Registrar's signature)

OCT 17 1944

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 John Ogroski
Licensed Embalmer No. 3398
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, fact should be so stated above.