

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence: # 501 Clara 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 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. # 501 Clara Ave.
(If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Grace Good Clarke

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

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Chauncey Clarke 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 12 1886
(Month) (Day) (Year)

8. AGE: Years 59 Months 2 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Richard L. Good

13. Birthplace Lexington Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Estelle Mauer

15. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Chauncey H. Clarke

(b) Address 501 Clara Ave., St. Louis

17. (a) removal (b) Date thereof 5-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo.

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) MAY 22 1945 (b) J. F. Bruce
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18 year 1945
hour 1 minute A M

21. I hereby certify that I attended the deceased from May 15 1945 to May 18 1945

that I last saw her alive on 5-18 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis, Chronic
Arteriosclerosis
Hypertension
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Wm B. Keeney M. D. or other _____
Address 4200 Olive Date signed May 19 1945

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

OC
67
9

88-11-109. Kentucky
4500 Olive
FO-3800
1 to 3 P.M.

4501

4501

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 J. D. Lupton
Licensed Embalmer No. 2122
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.