

S. No. 2
M-543
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21787**
Registrar's No. **6570**

FILED AUG 3 1945
Registration District No. **818**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Bethesda Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether 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. 4616 McPherson Ave.,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME ADA JANE CLAYTON.

3. (b) If veteran, name war none. 3. (c) Social Security 488-10-8686.

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

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

7. Birth date of deceased December 25, 1875.
(Month) (Day) (Year)

8. AGE: Years 69. Months 7. Days 29. If less than one day hr. min.

9. Birthplace Cheshire, England. 4
(City, town, or county) (State or foreign country)

10. Usual occupation Millinery Dep't.,

11. Industry or business Scruggs-Vandervoort & Barney Dept. Store.

MOTHER FATHER

12. Name John Clayton.

13. Birthplace Unknown, England. 4
(City, town, or county) (State or foreign country)

14. Maiden name Ann Chapman.

15. Birthplace Unknown, England. 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Thelma C. Stiers.

(b) Address 6260 Cates Avenue.

17. (a) Cremation. (b) Date thereof 7/27/45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory

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

(b) Address JOE 327 D 1945

19. (a) Jul 27 1945 (b) J.F. Budeck
(Date of registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25th,
year 1945. hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 18, 1945 to July 25, 1945
that I last saw him alive on July 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the breast
Due to metastasis
Due to metastasis

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

Major findings: same as above
Of operations _____
Of autopsy _____

Duration 3 mo
?
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 J.D. Seabaugh (M.D. or other) MD
Address Webster Groves, Mo Date signed 7-16-45

*Dr. Leathough
105 W. Lockwood.
3-5 p.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 *Bradford A. Melen*

Licensed Embalmer No. *2901*

P. O. Address *University City, 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.