

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
**FILED NOV 2 1945 STANDARD CERTIFICATE OF DEATH**

State File No. **32133**  
Registrar's No. **9199**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Homer G. Phillips Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 Days 7 Hrs.**  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County.....  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2711 Stoddard**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Joseph McClomb**  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **9** day **23**  
year **1945** hour **1** minute **43** A.M.  
21. I hereby certify that I attended the deceased from **5:59 P. M.**  
**9 - 18** 19**45**, to **1:43 A.M., 9-23** 19**45**.  
that I last saw him alive on **9 - 23** 19**45**  
and that death occurred on the date and hour stated above.

4. Sex **Male** 2  
5. Color or race **Negro**  
6. (a) Single, widowed, married, divorced.....  
6. (b) Name of husband or wife.....  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **9 18 45**  
(Month) (Day) (Year)

Immediate cause of death.....  
**Prematurity**  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
**4 7 hr. 44 min.**

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

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

10. Usual occupation.....  
11. Industry or business.....

MOTHER FATHER {  
12. Name **Gentle Joseph McClomb**  
13. Birthplace **Marianna Arkansas**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Theresa Booker**  
15. Birthplace **Marianna Arkansas**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Catherine M. Howard, M.D.**  
(b) Address **2601 N. Whittier Street**  
17. (a) **Burial** (b) Date thereof **10-25-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

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?.....

(c) Place: burial or cremation **CITY CEMETERY**  
18. (a) Signature of funeral director **Y. B. Hudson**  
(b) Address **City Health Dept.**  
19. (a) **10-25-45** (b) **J. F. Breakeak**  
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place)  
(e) Means of injury?.....  
23. Signature **West Sinker** (M. D. or M.M.K.)  
Address **2601 N. Whittier** Date signed **10-20-45**

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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.....

.....  
Licensed Embalmer No.....

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.**