

S. No. 2
A-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42246

State File No. _____

FILED JAN 13 1947
318

Registrar's No. 11362

Registration District No. _____

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Children's
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County Franklin 199
(c) City or town West Frankfort
(If outside city or town limits, write "RURAL")
(d) Street No. R.R #1
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME Brent Moore Clark

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 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 12 10 46
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Herrin Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Clifford Eugene Clark

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

14. Maiden name Martha Moore

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

16. (a) Informant J. Ziemler
(b) Address 500 S. Kings Highway

17. (a) Removal (b) Date thereof 1-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Frankfort, Ill.

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

(b) Address _____
19. (a) JAN 2 - 1947 (b) J. F. Braxton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 31
year 46 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from 12-11-1946 to 12-31-1946
that I last saw him alive on 12-31-1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Septicemic aneurysm - post-operative
Pneumonitis

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 1578

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. J. Blum (M. D. or other) _____

Address 100 S. Kings Highway Date signed _____

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

MOTHER FATHER

41030

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 Elmer R. Cadwell

Licensed Embalmer No. 4077

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.