

No. 2
1-2-43
5-17-39
235837

FILED FEB 3 1947 318

Registration District No.

Primary Registration District No.

1003

State File No.

Registrar's No. 609

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:
CITY HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **5 weeks**
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **CHARLES CLARK**

3. (b) If veteran, name war..... 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **ISABEL JAN** 6. (c) Age of husband or wife if alive **24** years

7. Birth date of deceased **JAN 24 1866**
(Month) (Day) (Year)

8. AGE **80** Years **11** Months **24** Days If less than one day hr. min.

9. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED FARMER**

11. Industry or business

12. Name **JOHN CLARK**

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

14. Maiden name **UNKNOWN**

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

16. (a) Informant **CARRIE AKERS**
(b) Address **3207 S. 9th**

17. (a) **BURIAL** (b) Date thereof **1/21/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WILBOURN MO**

18. (a) Signature of funeral director **J. F. Bussack**
(b) Address **2906 S. ...**

19. (a) **JAN 24 1947** (Date received) **J. F. Bussack** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **24**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **3207 S. 9th St.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **18**
year **47** hour **11** minute **35 P.** M.

21. I hereby certify that I attended the deceased from **Dec 12**, 19**45** to **Jan 18**, 19**47**
that I last saw him alive on **Jan 18**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **cardiac insufficiency** Duration **2 months**

Due to **arterio-sclerotic heart disease** 7 years

Due to.....
Other conditions (Include pregnancy within 3 months of death) **0/3**

Major findings: Of operations.....
Of autopsy **As above**
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?.....
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (c) Means of injury.....

23. Signature **Herbert C. ...** (M. D. or other) **0**
Address **1515 Lafayette St. St. Louis, Mo.** Date signed **1/19/47**

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

MOTHER FATHER

609

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..... *Ray E. Campbell*

Licensed Embalmer No. *881*

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.

Registration District No. 318

Primary Registration District No. 1003

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:

(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)

3. (a) PRINT FULL NAME

Charles Clark

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

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

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

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 Days 24 If less than one day.....hr.....min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....
year 1947 (hour)..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
that I last saw him..... above on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

2339

Pa-130