No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 16 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

29720

State File No. 0

Registration District No. 377

Primary Registration District No. 3063

Registrar's No. 1659

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 52 Aberdeen Pl
(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 St. Louis 96
(c) City or town Clayton 2
(If outside city or town limits, write "RURAL")
(d) Street No. 52 Aberdeen Pl 2
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME Clara E. Hailman
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
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 1/29/1874 (Month) (Day) (Year)

8. AGE: Years 73 | Months 6 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace St. Louis (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation Private Secretary
11. Industry or business National Lead Co
FATHER
12. Name John E. Hailman
13. Birthplace Westport (City, town, or county) New York (State or foreign country)
MOTHER
14. Maiden name Mary Collins
15. Birthplace Belfast (City, town, or county) Ireland (State or foreign country) 4
16. (a) Informant Mrs. Chas. H. Meyer
(b) Address 52 Aberdeen Pl
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/47 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery
18. (a) Signature of funeral director Robert J. Ambruster Inc
(b) Address 6633 Clayton Road
19. (a) 8-5-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 2
year 1947 hour ..... minute A. M.

21. I hereby certify that I attended the deceased from Sept. 1945 to Aug. 2, 1947; that I last saw her alive on Aug. 1 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhages	2 yrs.
Due to Hypertension, cardio vascular	10 yrs.
Due to 930	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause of 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 0

23. Signature [signature] (M. D. XXXXX)
Address 864 Hamilton Avenue St. Louis 12, Mo. Date signed 8-4-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

JUN 28 1949

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 Arnold U. Schoene

Licensed Embalmer No. 3864

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.