

FILED JUL 28 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24300

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6348

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:
St. Louis City Hospital - Max C. Starkloff
(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

CLARENCE GARNER

3. (b) If veteran, name war None

3. (c) Social Security No. 490-12-7501

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 January 23 1886
(Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days 23
If less than one day _____ hr. _____ min.

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

10. Usual occupation Houseman

11. Industry or business American Hotel

MOTHER FATHER {
12. Name Unavailable Garner
13. Birthplace Unavailable
(City, town, or county) (State or foreign country)
14. Maiden name Unavailable
15. Birthplace Unavailable
(City, town, or county) (State or foreign country)

16. (a) Informant City Hospital Records

(b) Address 1515 Lafayette Avenue

17. (a) Burial (b) Date thereof 7/17/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

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

(b) Address 4700 Washington Blvd

19. (a) JUL 18 1948 (b) Gay Srednicki
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Woods
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 218 N. 4th
Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th
year 1948 hour 3 minute 45 A.M.

21. I hereby certify that I attended the deceased from 7/7/48
_____, 19____, to July 16th, 1948
that I last saw him alive on July 16th, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of bladder, urinary 2 yr.
Duration _____

Due to _____
Due to 52
Other conditions (Include pregnancy within 3 months of death) _____

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?

(Specify type of place)
While at work? _____ Means of injury _____
23. Signature William W. Coats 7/16/48 (M. D. or other) W.D.
Address 1515 Lafayette Date signed 7-16-48

6348

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.