

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
#90768  
MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34100  
9512  
Registrar's No. \_\_\_\_\_

FILED NOV 12 1948  
318

Primary Registration District No. 100's

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 0 (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri County 050  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(c) Street No. 4 ACLEDE HOTEL  
Memorial (If rural, give location) 520 Chestnut  
(d) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CLARENCE EMERY  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M Color or race W  
5. Color or race \_\_\_\_\_  
6. (a) Single, widowed, married, divorced 1  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: SEPT 6 1894  
(Month) (Day) (Year)

8. AGE: Years 54 Months 1 Days 20 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace WHITEHALL ILL (City, town, or county) (State or foreign country)  
10. Usual occupation Unemployed

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name FRANK EMERY  
13. Birthplace CANADA (City, town, or county) (State or foreign country)  
14. Maiden name ADA DEVAULT  
15. Birthplace ILLINOIS (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maxine Webster  
(b) Address 5800 Embury  
17. (a) BURIAL (Burial, cremation, or removal)  
(b) Date thereof Nov. 3-48 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery  
18. (a) Signature of funeral director E. J. Schuur  
(b) Address 3125 Lafayette Av.  
19. (a) NOV 2 1948 (Date received from registrar)  
(b) J. B. Foster (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 1st  
year 1948 hour 11 minute 15 AM.  
21. I hereby certify that I attended the deceased from 10/8/48  
1948, to Oct. 8st 1948.  
that I last saw h im alive on Oct. 8st 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Psychic & other somatic disease, heart failure, arteriosclerosis  
Due to Heart Disease  
Due to \_\_\_\_\_  
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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Paul M. Caldwell M.D. (M. D. or other)  
Address 1515 Lafayette 11/1/48 Signed

WRITE PLAINLY—USE CAPS AND UNDERLINE

DEC 21 1948

**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

*John Blodgett*

Licensed Embalmer No. *4014*

P. O. Address

*3125 Dupuy St  
San Francisco, Calif*

**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. 218

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 Clarence Emery

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.....

7. Birth date of deceased Sept 6  
(Month) (Day) (Year)

8. AGE: Years 54 Months Days 22  
(Unless than one day hr. min.)

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

10. Usual occupation Employer

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.....

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

(b) Address.....

19. (a)..... (b) J. B. Foster  
(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 Nov Year 1948 Hour..... Minute..... M.

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

Duration

Due to.....

Due to.....

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

PHYSICIAN

Major findings:  
 Of operations.....

Of autopsy.....

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

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

SUPPLEMENTARY

WALLER, F. J. - USE CONTINUING BLACK INK - MAKE A PERMANENT RECORD

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3880

NOV 17 1948

S-39100

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