

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9899**  
**2515**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		17 19	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>#724 Belt Ave.,</b>				d. STREET ADDRESS (If rural, give location) <b># 724 Belt Ave.,</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>SUE</b>			b. (Middle) <b>TEMPLE</b>		c. (Last) <b>CLARK.</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>March 18, 1949</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 26 1867</b>		9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At. Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Edwardsville, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Samuel E. Temple.</b>			13b. MOTHER'S MAIDEN NAME <b>Julia Sappington.</b>		14. NAME OF HUSBAND OR WIFE <b>Edward Clark.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Julia Kraft; 724 Belt; St. Louis</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumonia - Hypostatic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Fracture h. forearm</b>				<b>4 days.</b>
			DUE TO (c) <b>Fall</b>				-
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>69050 (Mo) (Mo)</b>			
21d. TIME OF INJURY. <b>Mar 14 - 1949 m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Falls.</b>			
22. I hereby certify that I attended the deceased from <b>1945</b> , 19____, to <b>Mar 17</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>Mar 17</b> , 19 <b>49</b> , and that death occurred at <b>6:30P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>R. B. Barrett M.D.</b> (Degree or title)				23b. ADDRESS <b>5427 Delmar Blvd</b>		23c. DATE SIGNED <b>3-19-49.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24b. DATE <b>Mar. 21, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>MAR 21 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Foster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. R. Lupton &amp; Sons; 7233 Delmar Blvd.,</b>			

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

2515

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed

*Arnold W. Schoene*

Signed.....  
Student Embalmer

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.