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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25615**

FILED AUG 2 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **1763**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Lemay</b>	c. LENGTH OF STAY (in this place) <b>11</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lemay Nursing H. 9353 S. Broadway</b>		d. STREET ADDRESS (If rural, give location) <b>223 E. Schirmer St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Amy</b>	b. (Middle) <b>M.</b>	c. (Last) <b>Clifton</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 25 1949</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>November 24, 1871</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during usual working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Mose Stephens</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Johnson</b>	14. NAME OF HUSBAND OR WIFE <b>Wiley</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If you give year or dates of service) <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Wiley Clifton</b>	ADDRESS <b>223 E. Schirmer St.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral apoplexy</b>		?
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>334X</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 5, 1949**, to **July 24, 1949**, that I last saw the deceased alive on **July 24, 1949**, and that death occurred at **5 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>M. L. Bartmick</b>	23b. ADDRESS <b>7629 So. Broadway, Mo.</b>	23c. DATE SIGNED <b>7/25/49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>July 28, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>2000 Lemay Ferry Road, Lemay-Mo</b>
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DATE REC'D BY LOCAL REG. <b>7-25-49</b>	REGISTRAR'S SIGNATURE <b>Herbert C. Llanche, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>H. Hoffmeister</b>	ADDRESS <b>U. &amp; L. Co. 7814 S. Broadway</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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

*Harry J. Schumacher*

Signed.....

Student Embalmer

Licensed Embalmer No. 2679

P. O. Address 7814 T. Broadway

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.