

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39700

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>317</u>  |  | PRIMARY REG. DIST. NO. <u>4466</u>   |  | Registrar's No. <u>4292</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Indiana</u> b. COUNTY <u>White</u> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>Rock Hill</u>  |  | c. LENGTH OF STAY (in this place) _____  |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>Idaville</u>  |  | 111<br>12   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rock Hill Rest Home</u>   |  |  |  | d. STREET ADDRESS (If rural, give location)<br><u>rural - Idaville</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Nancy</u>   |  | b. (Middle) <u>Ann</u>   |  | c. (Last) <u>Clark</u>   |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Oct. 31, 1949</u>                       |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>   |  | 8. DATE OF BIRTH<br><u>June 24, 1872</u>  |  |
| 9. AGE (In years last birthday) <u>77</u>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Carroll Co., Indiana</u>            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Carroll Co., Indiana</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |
| 13a. FATHER'S NAME<br><u>Abraham Schonf</u>  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Sarah B. Fowler</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>James Edward Clark</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Merle S. Clark, 1040 Sylvan Pl.</u>  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>central hemiplegia</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) _____<br>11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>chronic myocarditis</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><br><br><br><br><br><br><br><br><u>334X</u> |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION<br><br><br><br><br><br><br><br><br><br><u>334X</u>  |  |  |  | 20. AUTOPSY?<br>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.) _____   |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____  |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR? _____   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>Oct 29</u> <sup>1949</sup> to <u>Oct 31</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>49</u> , and that death occurred at <u>9:40</u> a.m., from the causes and on the date stated above. |  |  |  |  |  |   |  |
| 23a. SIGNATURE<br><u>Albert H. Hoppe</u> (Degree or title)   |  |  |  | 23b. ADDRESS<br><u>3707 Poloma</u>   |  | 23c. DATE SIGNED<br><u>11-1-49</u>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |  | 24b. DATE<br><u>11-1-49</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Grove</u>   |  | 24d. LOCATION (City, town, or county) (State)<br><u>Monticello, Ind.</u>            |  |
| DATE REC'D BY LOCAL REG. <u>11-1-49</u>  |  | REGISTRAR'S SIGNATURE<br><u>Albert H. Hoppe</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Albert H. Hoppe, 4700 Washington Blvd.</u>  |  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

**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 M. C.

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed

Elton H. Remelius

Licensed Embalmer No.

4283

P. O. Address

St. Louis, Mo.

**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.