

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 14 1950

State File No. **24645**
Registrar's No. **8674**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8674					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) 25 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219					
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 2627 Dickson St							
3. NAME OF DECEASED (Type or Print) a. (First) Frank			b. (Middle) _____		c. (Last) Clark		4. DATE OF DEATH (Month) (Day) (Year) July 30 1950				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Louisiana			12. CITIZEN OF WHAT COUNTRY? U S A			
13a. FATHER'S NAME Harry Clark			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE None					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk		17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier					ADDRESS		
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				III		INTERVAL BETWEEN ONSET AND DEATH Undet.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive and Arteriosclerotic				Heart Disease							
ANTECEDENT CAUSES				DUE TO (b) Undetermined							
				DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS				None							
19a. DATE OF OPERATION None				19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		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? Head							
22. I hereby certify that I attended the deceased from 7-21 , 19 50 , to 7-30 , 19 50 , that I last saw the deceased alive on 7-30 , 19 50 , and that death occurred at 12:10pm. , from the causes and on the date stated above.											
23a. SIGNATURE A. Thompson				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 8-2-50					
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 8-5-50		24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cemetery		24d. LOCATION (City, town, or county) (State) St Louis, Mo					
DATE REC'D BY LOCAL REG. AUG 4 1950		REGISTRAR'S SIGNATURE J B Foster			FUNERAL DIRECTOR'S SIGNATURE Yuse Lowe ADDRESS 2930 Dickson St						

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Arthur L. Hilliard

Signed.....
Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 4049 St. Germain

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.