No. 300
10.48

FILED DEC 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42120
Registrar's No. 10329

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4451 Russell Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2179
d. STREET ADDRESS (If rural, give location): 4451 Russell Ave. 17

3. NAME OF DECEASED (Type or Print)
a. (First): Clara
b. (Middle): H.
c. (Last): Craig

4. DATE OF DEATH (Month) (Day) (Year): Dec. 3, 1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 14, 1883
9. AGE (In years last birthday): 67 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Sparta, Ill.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: John Butler
13b. MOTHER'S MAIDEN NAME: Sarah Reed
14. NAME OF HUSBAND OR WIFE: Charles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Charles Craig, 4451 Russell Ave.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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 ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 443X

22. *I hereby certify that I attended the deceased from* 6/16, 1950, *to* 12/3, 1950, *that I last saw the deceased alive on* 11/28, 1950, *and that death occurred at* 7:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William H. Grundmann M.D.
23b. ADDRESS: 3118 N. Grand Bl., St. Louis (7)
23c. DATE SIGNED: 12/4/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 12-5-50
24c. NAME OF CEMETERY OR CREMATORY: Caledonia
24d. LOCATION (City, town, or county) (State): Sparta, Ill.

DATE REC'D BY LOCAL REG.: DEC 4 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

Julia

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~~ [illegible]

working under my personal supervision.

Student Embalmer No. .....

Signed [illegible]

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.