

FILED MAR 5 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6296

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1529**

3
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2217	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION IN ROUGHT TO HOMER @ 21		2707 COLE ST.	

3. NAME OF DECEASED (Type or Print)	a. (First) ANNA	b. (Middle) LOU	c. (Last) CLARK	4. DATE OF DEATH (Month) (Day) (Year)
				2 14 1952

5. SEX F 3	6. COLOR OR RACE COL	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW 2	8. DATE OF BIRTH MAR 3, 1884	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 11 Days 9	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ATLANTA GA.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME CHARLIE CLARK	13b. MOTHER'S MAIDEN NAME ANNA LOU CLARK	14. NAME OF HUSBAND OR WIFE ALFONZO BOISSEAU
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Thelma Thomas	ADDRESS 2717² Cole
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Renal-Vascular Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension 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 none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)

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? H42X

22. I hereby certify that I attended the deceased from **1-31, 1952**, to **2-14, 1952**, that I last saw the deceased alive on **2-14, 1952**, and that death occurred at **6 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Tracy D. Alexander M.D. (Degree or title)	23b. ADDRESS 826 N. Channing St. St. Louis	23c. DATE SIGNED 2-16-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 2-21-52	24c. NAME OF CEMETERY OR CREMATORY LEATHER DICKSON	24d. LOCATION (City, town, or county) (State) KIRKWOOD MO.
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DATE REC'D BY LOCAL REG. FEB 18 1952	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON	ADDRESS 2707 STODDAR
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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.

Student
Student Embalmer

Signed Arthur L. Holliday

Licensed Embalmer No. 4221

P. O. Address 4524 Alden

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.