

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 29 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2430**

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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 3431 Pine Street	
3. NAME OF DECEASED (Type or Print) a. (First) Clay b. (Middle) c. (Last) Box		4. DATE OF DEATH (Month) (Day) (Year) March 7 1952	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married divorced	8. DATE OF BIRTH Aug. 7, 1908
9. AGE (In years last birthday) 43	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Greenville, Mississippi	12. CITIZEN OF WHAT COUNTRY? /
13a. FATHER'S NAME Henry Box	13b. MOTHER'S MAIDEN NAME Agnos (Unk)	14. NAME OF HUSBAND OR WIFE	
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. Unk	17. INFORMANT'S SIGNATURE OR NAME Ruth James, 3431 Pine Street	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prob. Coronary Thrombosis ANTECEDENT CAUSES DUE TO (b) Hypertensive Vascular Disease DUE TO (c) Undetermined 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 <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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H201	
22. I hereby certify that I attended the deceased from 11-5 , 19 51 , to 3-7 , 19 52 , that I last saw the deceased alive on 3-7 , 1952, and that death occurred at 6:25p m., from the causes and on the date stated above.			
23a. SIGNATURE H. J. Green (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 3-10-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3/15/52	24c. NAME OF CEMETERY OR CREMATORY Booker T. Washington	24d. LOCATION (City, town, or county) (State) E. St. Louis, Illinois
DATE REC'D BY LOCAL REG. MAR 14 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R. M. C. Green, 3517 Laclede Avenue	

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 Melvin E. Green

Licensed Embalmer No. 4478

P. O. Address St. Louis, Mo.

Signed
Student Embalmer

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.