

No. 300
10.48

OCT 22 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36252

State File No.

318

1003

Registrar's No. 9293

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
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 OR TOWN) St. Louis		c. LENGTH OF STAY (In this place) 5 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1907 N. Sarah St.				d. STREET ADDRESS (If rural, give location) 11 1907 N. Sarah St.			
3. NAME OF DECEASED (Type or Print) a. (First) Willie b. (Middle) Esther c. (Last) Clemons			4. DATE OF DEATH (Month) (Day) (Year) Oct. 4, 1952				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH Aug. 3, 1898	
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months 2 Days 1		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid			10b. KIND OF BUSINESS OR INDUSTRY Private Families		11. BIRTHPLACE (State or foreign country) Cottonplant, Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A
13a. FATHER'S NAME Albert Alley			13b. MOTHER'S MAIDEN NAME Fannie Freeman		14. NAME OF HUSBAND OR WIFE Deceased		
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. 499-34-4213		17. INFORMANT'S SIGNATURE OR NAME Mrs. Demetrice Caldwell			ADDRESS 1907 N. Sarah
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) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Apoplexy DUE TO (c) Chronic Bright			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Disease				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 334X			
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>10 30A</u> , 19 <u>52</u> , and that death occurred at <u>10 30A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Patricia E. Taylor Coranor				23b. ADDRESS 1300 Pearl		23c. DATE SIGNED 10-7-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 9, 1952	24c. NAME OF CEMETERY OR CREMATORY Ash Grove Cemetery		24d. LOCATION (City, town, or county) (State) Cottonplant, Arkansas		
DATE REC'D BY LOCAL REG. OCT 7 1952		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE C. J. Nash		ADDRESS 3847 Page	

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

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 _____

Licensed Embalmer No. 2432

P. O. Address 3847 Page Bl

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.