

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40608

State File No. _____

FILED DEC 2 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10311**

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, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) 23 2500 S. 18th St.	

3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) M. c. (Last) PICKERING			4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 7, 1952		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH Aug. 29, 1888	9. AGE (In years last birthday) 64	10. UNDER 1 YEAR Months 2 Days 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME William Stohlmann		13b. MOTHER'S MAIDEN NAME Amelia Summerfield		14. NAME OF HUSBAND OR WIFE Howard Pickering	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Robert W. Pickering	
				ADDRESS 2215 Aberdeen	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple sclerosis		DUE TO (b) _____				
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		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 <input 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? 345X		

22. I hereby certify that I attended the deceased from **8-31-52**, 19____, to **11-8-52**, 19____, that I last saw the deceased alive on **11-7-52**, 19____, and that death occurred at **10:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dorcas Bailes MD		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 11-8-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-10-52		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	
		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.			

DATE REC'D BY LOCAL REG. NOV 10 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Jay B. Smith	
				ADDRESS 7150 Manchester, Maplewood, Mo.	

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 J. P. Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.