

11589

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. ....

No. 300  
10-48

FILED MAR 18 1953

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1003

2129

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. ....	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Morgan</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Jacksonville</u>		8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>614 So. Main Street</u>			
3. NAME OF DECEASED a. (First) <u>Clarence</u>		b. (Middle) <u>A.</u>		c. (Last) <u>German</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 23 53</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 26, 1899</u>		9. AGE (In years last birthday) <u>53</u>	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) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Jacksonville, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John L. German</u>		13b. MOTHER'S MAIDEN NAME <u>Henrietta Man</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel T. German</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mabel T. German, Jacksonville, Ill.</u>			
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) <u>Brain Tumor non-malignant</u> 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 <u>Rt. frontal craniotomy - Astrocytoma like tumor</u>				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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>223X</u>			
22. I hereby certify that I attended the deceased from <u>Feb. 14, 1953</u> , to <u>Feb. 23, 1953</u> , that I last saw the deceased alive on <u>Feb. 23, 1953</u> , and that death occurred at <u>6:50A m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>F.R. Bradley</u>		(Degree or title) <u>M. D.</u>		23b. ADDRESS <u>BARNES HOSPITAL</u>		23c. DATE SIGNED <u>2/23/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2-23-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Lawn Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Jacksonville, Ill.</u>	
DATE REC'D BY LOCAL REG. <u>FEB 24 1953</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

*Robert M. Murray*

Licensed Embalmer No.

*3749*

P. O. Address

*St. Louis, Mo.*

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.