

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15591

FILED APR 23 1953

1003

State File No. ....

3865

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		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 <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2109</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>10 3116 N Taylor 0</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Clarence</b> b. (Middle) _____ c. (Last) <b>Craig</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 8 1953</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>2-2-1900</b>	
9. AGE (In years, last birthday) <b>53</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>CALIFORNIA MO.</b>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <b>George CRAIG</b>		13b. MOTHER'S MAIDEN NAME <b>Gertrude Henderson</b>		14. NAME OF HUSBAND OR WIFE <b>Charlie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>CHARLIE CRAIG 3116 N TAYLOR</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hepato-renal Failure</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Post-operative right Hemi-Colectomy</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Carcinoma of Ascending Colon with Extension Diabetes Mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
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) _____		21f. HOW DID INJURY OCCUR? <b>153X</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <b>3-23</b> , 19 <b>53</b> , to <b>4-8</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>4-8</b> , 19 <b>53</b> and that death occurred at <b>6:00 p. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Carl B. Smith, D. O.</b>			23b. ADDRESS <b>2601 N Whittier St.</b>			23c. DATE SIGNED <b>4-9-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removed</b>		24b. DATE <b>4-14-53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON PARK</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis county MO.</b>	
DATE REC'D BY LOCAL REG. <b>APR 14 1953</b>		REGISTRAR'S SIGNATURE <b>Carl B. Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>BENNIE LOVE 3103 WASHINGTON</b>			

(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 *H. Claude Gordon*

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

**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.