

FILED JUN 1 - 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19328

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4887**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) ARNOLD	4000 1
d. FULL NAME OF HOSPITAL OR INSTITUTION ALEXIAN BROS HOSPITAL		d. STREET ADDRESS (If rural, give location) P. R. #2	

3. NAME OF DECEASED (Type or Print) a. (First) CLYDE	b. (Middle) C.	c. (Last) DEWISLE	4. DATE OF DEATH (Month) (Day) (Year) MAY 13 - 1953
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MCH. 26 - 1904	9. AGE (in years) (Month) (Day) 49	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY KOHLER CRAFT CO	11. BIRTHPLACE (State or foreign country) Mo	12. CITIZEN OF WHAT COUNTRY? D
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13a. FATHER'S NAME GIRARD DEWISLE	13b. MOTHER'S MAIDEN NAME EVA YOUNG	14. NAME OF HUSBAND OR WIFE LILLIAN
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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 Mrs Lillian de Lisle - Arnold, Mo.	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH 9 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 4201
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22. I hereby certify that I attended the deceased from **May 4**, 19**53**, to **May 13**, 19**53**, that I last saw the deceased alive on **May 13**, 19**53**, and that death occurred at **1 P.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) B. J. Mc Grinnis M.D.	23b. ADDRESS 16 Reampton Village	23c. DATE SIGNED 5/14/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE MAY 15 - 1953	24c. NAME OF CEMETERY OR CREMATORY PORTAGEVILLE, MO	24d. LOCATION (City, town, or county) (State) PORTAGEVILLE, MO
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DATE REC'D BY LOCAL REG. MAY 14 1953	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE L. MULLEN UNO Co	ADDRESS 5165 DELMAR
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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 _____

M. W. Ruter

Licensed Embalmer No. 4865

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.