

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33019

State File No.

9489

FILED OCT 15 1953

BIRTH NO.

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2641 LUCAS		d. STREET ADDRESS (If rural, give location) 2641 LUCAS	
3. NAME OF DECEASED (Type or Print) a. (First) CHARLEY b. (Middle) CLAYTON c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 9 30 53
5. SEX M	6. COLOR OR RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT 4 1890
9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS. Hours 2 21 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) LUNA LANDING ARK.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME EMANUEL CLAYTON		13b. MOTHER'S MAIDEN NAME HANNAH WIGFALL	
14. NAME OF HUSBAND OR WIFE BESSIE CLAYTON		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 Bessie Clayton 2641 Lucas	
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) CORONARY THROMBOSIS ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROSIS DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NO	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION NO	
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)	
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		22. I hereby certify that I attended the deceased from 9/20 , 19 50 , to 9/30 , 19 50 , that I last saw the deceased alive on 19 , and that death occurred at m. , from the causes and on the date stated above.	
23a. SIGNATURE [Signature]		23b. ADDRESS 2222 Jefferson	
23c. DATE SIGNED 10/2/53		24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 10-5-53		24c. NAME OF CEMETERY OR CREMATORY GREENWOOD	
24d. LOCATION (City, town, or county) (State) WELLSVILLE MO		25. FUNERAL DIRECTOR'S SIGNATURE A. F. Walton	
25. ADDRESS 2707 St. Charles		DATE REC'D BY LOCAL REG. OCT 3 1953	
REGISTRAR'S SIGNATURE J. Earl Smith		25. ADDRESS	

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

* (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

Arthur L. Heikkinen

Licensed Embalmer No. *4231*

P. O. Address *4524 Urdian*

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.