No. 300
10.48

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

FILED SEP 24 1953 46204

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33022

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8264

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Barnes Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2249
d. STREET ADDRESS (If rural, give location): 3740 Marine Ave

3. NAME OF DECEASED (Type or Print)
a. (First): Opal
b. (Middle): Marie
c. (Last): Clemons

4. DATE OF DEATH (Month) (Day) (Year): 6-28-53

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: 6-26-53
9. AGE (In years last birthday): If under 1 year: Months: ; Days: 2 ; If under 1 hr.: Hours: 1 ; Min.: 12

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~
10b. KIND OF BUSINESS OR INDUSTRY: ~
11. BIRTHPLACE (State or foreign country): ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Harvey Edward Clemons
13b. MOTHER'S MAIDEN NAME: Geneva Pearl McMullin
14. NAME OF HUSBAND OR WIFE: ~

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: Harvey Clemons
ADDRESS: 3740 Marine

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature — Inter Cranial Hemorrage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fall Presenting, Forceps Delivery —
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 7605

22. *I hereby certify that I attended the deceased from* 6/26, 1953 *to* 6/28, 1953 *that I last saw the deceased alive on* 6/27, 1953, *and that death occurred at* 4:25 m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. W. Barker (Degree or title): MD
23b. ADDRESS: 1506 S Jefferson
23c. DATE SIGNED: 6/28/53

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE: AUG 31 1953
24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL: AUG 26 1953
REGISTRAR'S SIGNATURE: J. Earl Smith, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: Rowland Mortuary Service
ADDRESS: 4104 Manchester Ave.

(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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.